Rural Physician Study Committee

Report of the Rural Physician Study Committee

December 2003

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Committee Members

Senator Marsha Arzberger, Co-Chair
Representative Phil Hanson, Co-Chair
Senator Tim Bee
Representative Amanda Aguirre
Dr. Jim Carland
Mr. Chris Cronberg
Dr. Brian Grogan
Ms. Alison Hughes

Report of the Rural Physician Study Committee

Introduction

This final report summarizes the efforts of the Rural Physician Study Committee. As required by the legislation, this report is being submitted to the President of the Senate, the Speaker of the House of Representatives and the Governor.

Committee Purpose

The Rural Physician Study Committee, established pursuant to Laws 2002, Chapter 169, was charged with the following:

1. Examine federal and State programs relating to malpractice insurance pools, and malpractice insurance premium sharing;
2. Examine the effect of the cost and availability of malpractice insurance on the practice of obstetrical medicine, and hospitals and community health centers in rural areas of Arizona; and
3. Review any other information relating to the availability of obstetrical services in rural areas of Arizona.

The Committee is repealed from and after December 31, 2003.

Committee Membership

Pursuant to the legislation, the Committee consists of eight members:

House — Two members of the House of Representatives, from different political parties and one designated as Co-Chair, appointed by the Speaker of the House of Representatives:
Hanson (Co-Chair), Aguirre

Senate — Two members of the Senate, from different political parties and one designated as Co-Chair, appointed by the President of the Senate:
Arzberger (Co-Chair), Bee

Other — One representative of a malpractice insurer that sells malpractice insurance in Arizona, appointed by the Speaker of the House of Representatives:
Dr. Jim Carland, President and CEO, MICA

One administrator from a hospital that is located in a rural area of Arizona, appointed by the Speaker of the House of Representatives:
Mr. Chris Cronberg, Northern Cochise Community Hospital

One physician who is a licensed doctor of medicine or doctor of osteopathy, whose primary practice is in rural Arizona and who specializes in obstetrical medicine, appointed by the President of the Senate:
Dr. Brian Grogan

The Director of the Rural Health Office at the University of Arizona or the Director's designee:
Ms. Alison Hughes, College of Public Health, University f Arizona

Committee Activities

The Committee held three meetings during the past two years. The following provides a summary of each meeting, but please see the attached minutes and handouts for the Committee discussions and testimony.

September 18, 2002

The first meeting of the Committee began with introductions and a review of the committee charge.

There were four presentations given to the Committee:

- Overview of the medical malpractice problem facing rural hospitals – Jim Dickson, Chief Executive Officer, Copper Queen Hospital
- Presentation on malpractice issues affecting medical practice – Dr. Mari Rowe, Copper City Physicians
- Presentation on malpractice insurance principles – Ron Malpiedi, Vice President and Chief Operational Officer, Mutual Insurance Company of Arizona
- Overview of malpractice laws in Arizona and other states – House staff

January 7, 2003

The second meeting of the Committee began with introductions of new Committee members: Senator Tim Bee was appointed to replace Senator Edward Cirillo and Representative Robert Cannell was appointed to replace Representative Mark Clark.

There were four presentations given to the Committee:

- Presentation on the status of Sage Memorial Hospital – Jayne Scalise, Chief Executive Officer, Sage Memorial Hospital, Ganado, Arizona
- Presentation on the legal elements regarding malpractice lawsuits – Bill Jones, Senior Partner of Jones, Skelton and Hochuli Law Firm
- Presentation on the California's model for malpractice reform – House Staff
- Overview of the malpractice insurance crisis in other states – Dr. Jim Carland, Mutual Insurance Company of Arizona

December 2, 2003

The final meeting of the Committee began with introductions of new Committee members: Representative Phil Hanson was appointed to replace Representative Edward Poelstra as co-chair and Representative Amanda Aguirre was appointed to replace Representative (now Senator) Robert Cannell.

There were five presentations given to the Committee:

- Review of last session's medical malpractice legislation – Senate Staff
- Update on California's model for malpractice reform – House Staff
- Update on other state's medical malpractice reform – House Staff
- Review of the Arizona constitution relating to damages – Senate Staff
- Presentation on Proposition 12, Texas initiative on capping damages – Senate Staff .

The Committee adopted three recommendations, as described below.

Public Participation
Aside from the scheduled presentations to the Committee, public testimony was provided by the following individuals:

Arizona Family Care Associates
Medical Indemnity Group
Department of Insurance
Arizona Association of Homes and Housing for the Aging
Governor's Advisory Council on Aging

Recommendations

The Committee adopted the following recommendations:

The Rural Physician Study Committee encourages the Legislature:

(a) to continue the study committee with a new charge to monitor the multiple and complex issues affecting the delivery of medical care in this state that focuses on professional malpractice liability on access to care and quality of care and on critical issues relating to physicians, hospitals and nursing homes.

(b) to work collaboratively with stakeholders to develop strategies that meet the goals of ensuring the availability of qualified healthcare personnel at all levels of the health care system, enhancing quality medical care, adequately compensating those injured by negligent medical care while ensuring balance in assessing medical negligence, and promoting the availability of (and viability of the companies providing) liability insurance to qualified medical practitioners.

(c) to request that a standing committee of the House of Representatives and/or Senate such as Insurance/Finance investigate the possibility of placing limits on malpractice suits; thus encouraging physicians to continue to maintain their practices in rural communities.

Attachments

- Enabling Legislation – Laws 2002, Chapter 169
- Meeting minutes/handouts – September 18, 2002, January 7, 2003 and December 2, 2003

House Engrossed Senate Bill

State of Arizona
Senate
Forty-fifth Legislature
Second Regular Session
2002

CHAPTER 169

SENATE BILL 1240

AN ACT

ESTABLISHING THE RURAL PHYSICIAN STUDY COMMITTEE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Rural physician study committee; membership; duties; report

A. The rural physician study committee is established consisting of the following members:

1. Two members of the house of representatives who are appointed by the speaker of the house of representatives and who are not members of the same political party. The speaker of the house of representatives shall appoint one of these members as cochairperson of the committee.

2. Two members of the senate who are appointed by the president of the senate and who are not members of the same political party. The president of the senate shall appoint one of these members as cochairperson of the committee.

3. An administrator from a hospital that is located in a rural area of this state. The speaker of the house of representatives shall appoint this member.

4. A physician who is licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes, whose primary practice is in the rural areas of this state and who specializes in obstetrical medicine. The president of the senate shall appoint this member.

5. The director of the rural health office at the university of Arizona or the director's designee.

6. A representative of a malpractice insurer that sells malpractice insurance in this state. The speaker of the house of representatives shall appoint this member.

B. Committee members are not eligible to receive compensation.

C. The committee shall:

1. Examine federal and state programs relating to:

(a) Malpractice insurance pools.

(b) Malpractice insurance premium sharing.

2. Examine the effect of the cost and availability of malpractice insurance on:

(a) The practice of obstetrical medicine in rural areas of this state.

(b) Hospitals and community health centers in rural areas of this state.

3. Review any other information relating to the availability of obstetrical services in rural areas of this state.

D. The committee may use the services of legislative staff as required.

E. On or before December 31, 2003, the committee shall submit a written report of its findings and recommendations to the speaker of the house of representatives, the president of the senate and the governor. The committee shall provide a copy of the report to the secretary of state and the director of the Arizona state library, archives and public records.

Sec. 2. Delayed repeal

Section 1 of this act, relating to the rural physician study committee, is repealed from and after December 31, 2003.

APPROVED BY THE GOVERNOR MAY 06, 2002.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 07, 2002.

Agendas can be obtained via the Internet at http://www.azleg.state.az.us/iagenda/iagenda.htm

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

RURAL PHYSICIANS STUDY COMMITTEE

Date: **Wednesday, September 18, 2002**

Time: **10 a.m.**

Place: **Senate Hearing Room 1**

AGENDA

1. Opening Remarks and Introductions
2. Review of Committee Charge – Staff
3. Presentations on the Medical Malpractice Problem
   - Hospital: Jim Dickson, Chief Executive Officer, Copper Queen Hospital
   - Doctors: Dr. Jose Romo, Copper City Physicians
     Dr. Mari Rowe, Copper City Physicians
   - Insurance: Ron Malpiedi, Chief Financial Officer, Mutual Insurance Company of Arizona
4. Overview of Malpractice Laws in Arizona and Other States – Staff
5. Public Testimony
6. Committee Discussion
7. Adjourn

Members:

Senator Marsha Arzberger, Cochair
Senator Edward Cirillo
Dr. Jim Carland
Dr. Brian Grogan
Representative Edward Poelstra, Cochair
Representative Mark Clark
Chris Chronberg
Alison Hughes

Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602)542-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

JK/cd 08/27/02

CORRECTED CORRECTED CORRECTED

ARIZONA STATE LEGISLATURE

RURAL PHYSICIANS STUDY COMMITTEE

Minutes of the Meeting
Wednesday, September 18, 2002
10 a.m., Senate Hearing Room 1

Members Present:
Senator Marsha Arzberger, Cochair
Senator Edward Cirillo
Chris Cronberg
Alison Hughes
Representative Edward Poelstra, Cochair
Dr. Jim Carland
Dr. Brian Grogan

Memb rs Absent:
Representative Mark Clark

Staff:
Julie Keane, Senate Health Committee Analyst
Pete Wertheim, House of Representatives Health Committee Analyst
Tracey Landers, Senate Health Committee Assistant Analyst

Chairman Arzberger called the meeting to order at 10:02 a.m. and introduced the members of the Committee.

Julie Keane, Senate Health Committee Analyst, explained that the charge of the committee is to: 1) examine federal and State programs relating to malpractice insurance pools and premium sharing; 2) examine the effect of the cost and availability of malpractice insurance on the practice of obstetrical medicine in hospitals and community health centers in rural Arizona; and 3) review any other information relating to the availability of obstetrical services in rural Arizona. The Committee is required to submit a written report of its findings and recommendations to the Speaker of the House of Representatives, the President of the Senate, and the Governor on or before December 31, 2003 and provide a copy of the report to the Secretary of State and the Director of the Arizona State Library, Archives and Public Records. The Committee is repealed on December 31, 2003.

Jim Dickson, Chief Executive Officer, Copper Queen Hospital, distributed a handout (Attachment 1) and provided an overview of the medical malpractice problem facing rural hospitals. He pointed out that the majority of rural Arizona is classified as a medically underserved area and a healthcare professional shortage area failing to meet minimum federal standards for patient physician ratios. He emphasized that access to healthcare is becoming a critical problem in many Arizona rural areas.

Mr. Dickson noted that hospitals have supported and subsidized physician practices because the rural hospitals and doctors servicing those hospitals are very much

integrated. However, as hospital margins decline, they are unable to subsidize these practices.

Mr. Dickson explained that the national percentage of uninsured is 16% while Arizona's uninsured rate is at 23%, which means almost one in four patients does not have insurance. He added that when measuring the uninsured, it does not include the transient population crossing the Mexican border. He noted that Arizona ranks 17th in managed care penetration, which reduces income to the physicians because they must negotiate rates. The margin of uninsured and managed care causes suppression of physician income. When there are increases in expenses, physicians have no way to recoup them.

Mr. Dickson stressed that it was devastating when over 40% of the medical malpractice insurance carriers stopped providing coverage for Arizona in November, 2001. This forced hospitals and physicians to look elsewhere for malpractice insurance, causing them to pay huge sums for "tail coverage." In Cochise County, 80% of the physicians lost their malpractice coverage. He mentioned that hospitals have had to close their obstetrics departments and the surgery programs are also in jeopardy. There are only two remaining general surgeons in Cochise County. Many physicians have left the area because of the increases in the malpractice insurance.

Mr. Dickson emphasized that there are not enough healthcare dollars in the rural areas. There are too many uninsured, underinsured, and transient population wearing away at the physicians' normal base of income. He noted that there has been an inordinate growth in the use of emergency rooms, which is the most expensive way to give healthcare. He added that with decreased availability of physicians, the emergency room volume rose from 250 a month to over 550 a month during the last year.

Mr. Dickson next discussed their recommendations: 1) implement the various aspects of tort reform; 2) preserve Arizona Health Care Cost Containment System (AHCCCS) funding; 3) enhance primary care through federally qualified healthcare clinics (FQHC); and 4) continue lobbying the federal government. He referred to an attachment in his handout, the Medical Malpractice report issued by the United States General Accounting Office (GAO), which covers tort reforms in depth. He pointed out that the FQHC receives additional funding from the federal government. He suggested that the State should encourage more FQHC in the rural areas in order to assist physicians who cannot afford the malpractice insurance.

Senator Arzberger asked for a clarification that the FQHC are not receiving additional funds for border crossers. Mr. Dickson replied no, however, the federal government reimburses the physician at cost and is paid regardless of how many patients he gives care to. Senator Arzberger said that she was not aware that any of the border crossers were taken to an FQHC by border patrols. Mr. Dickson replied that is correct, the border crossers actually are walk-ins. The border patrol does not take anyone to a clinic because the individual would be in custody and they would have to pay.

Senator Cirillo questioned if Cochise County has benefited from the University of Arizona (UA) scholarship program. Mr. Dickson responded that he was not aware of

any benefit from that program. He added that it is extremely difficult to recruit in the rural areas because of the adverse climate. Admissions in both hospitals in the area are down by 50% and the hospitals are financially in jeopardy.

Senator Cirillo indicated that the Arizona Trial Bar is flush with money supporting legislators who will block tort reform. He emphasized that he has supported tort reform for many years and feels it is important to pursue or the State will face many problems.

Mr. Dickson stressed that malpractice insurance is hurting Arizonans. The lack of physicians in healthcare will hurt more people and cause more damage to the health of Arizona citizens than any malpractice rights that are preserved. This is a critical issue that is getting worse.

Dr. Carland commented that he agrees with much of what Mr. Dickson has discussed; however, he feels these issues are not limited to the rural areas. Maricopa County falls well under the Bureau of Health Professional standards and the Graduate Medical National Advisory Committee levels for physicians per 100,000. Cochise County has more physicians per 100,000 than Maricopa County. Mr. Dickson responded that the problem with Cochise County is the mal-distribution of physicians.

Ms. Hughes indicated that there are a number of J1 visa physicians practicing in Cochise County and asked for an explanation of what a J1 visa physician is and how the malpractice issue is affecting their capacity to practice. Mr. Dickson replied that they have the same environment as all other physicians. There are specific areas of the State that are designated as medically underserved and healthcare professional shortage areas. The federal government will allow visas for foreign doctors to practice in those areas and will allow them to stay in America once they have completed their medical service under the J1 visa. Currently, there are two or three J1 physicians in Douglas and none in Bisbee. However, once they complete the J1 visa, they will leave the area.

Mr. Cronberg mentioned that he is aware that several of the hospitals in Cochise County have closed their obstetric programs recently and wondered what the burden has been on the Sierra Vista hospital and physicians. Mr. Dickson answered that the Sierra Vista hospital is overburdened and they are expanding their obstetrics unit. He mentioned that one specific problem in Cochise County is that there is no prenatal care given to mothers, with many babies born in emergency rooms.

Dr. Grogan asked if the FQHC are opened 24 hours a day seven days a week. Mr. Dickson replied no. Operation of the clinic is up to the clinic's board and administration. They can stay open longer hours which would alleviate the need for patients to seek healthcare in emergency rooms.

Dr. Grogan questioned if these programs are going to compete with private practice physicians. Mr. Dickson replied absolutely. Five to ten years ago, Cochise County had excellent healthcare availability; however, it has totally collapsed. He suggested that if the malpractice insurance premiums continue to increase, he does not know how physicians will be able to stay in business.

Dr. Mari Rowe, Copper City Physicians, discussed how the malpractice issue affects her practice. She explained that she has been a physician in Douglas for 16 years and has never been sued nor had any problems before the medical board. She indicated that she came to Douglas because she wanted to live and work in a small town and wanted to feel that she was helping people in an underserved area. She stressed that most doctors in these areas want to be there. She noted that malpractice issues have affected her in many ways over the years, not only in her daily decisions but on major concerns such as who she practices with and how. Her first practice was with one other doctor; however, that doctor was unable to pay for her "tail coverage." She spent ten years in a larger group of doctors where they could afford to pay the "tail coverage." Four years ago, she joined several of those doctors in forming their own practice and each year progressed financially. However, this year their malpractice insurance company decided to leave the state. Going to a new company increased their premiums and they had to pay the "tail coverage" from the old premium. It was extremely difficult to stay in business; however, with a small bank loan, they were able to do so. It now appears that their malpractice insurance will double again next year and they probably will not be in a position to pay it. They have been negotiating with the hospitals to assist them but they are unable to help.

Dr. Rowe pointed out that there is the federal program; however, most physicians are not happy working for them. Doctors need independence in their practice and want to make their own decisions, which is difficult in the federal programs. Another problem with the federal program is they heavily rely on nurse practitioners and physicians assistants. Most doctors feel uncomfortable working with the clinic's level of unsupervision of the nurse practitioners and physicians assistants.

Dr. Rowe indicated that aside from the financial concerns, there is a day-to-day affect of malpractice on how she practices. There have been many changes in medicine since she began practicing. Managed care and insurance changes have occurred, patients' expectations have changed, and doctors expect more free time. She commented that the problem with malpractice is not the fact that if she does something wrong, she has to pay for it. That is understandable. However, there is an arbitrary sense to malpractice that may occur even when a physician does not do anything wrong.

Dr. Rowe concluded that she does not see malpractice as an insurmountable obstacle that cannot be overcome. However, this is the first time she feels that she may not be able to continue to practice in Douglas. She stressed that it is an obstacle that she is not able to conquer on her own and needs the help of the Legislature and malpractice industry.

Ron Malpiedi, Vice President and Chief Operational Officer, Mutual Insurance Company of Arizona, (MICA), distributed a handout (Attachment 2) covering basic insurance principles. In response to Senator Arzberger's question, he noted that there are several malpractice carriers in Arizona. However, MICA insures 75% of the doctors in Arizona.

Mr. Malpiedi next discussed income and expenses of malpractice insurance carriers. Currently, overhead expenses are increasing and the investment incomes are decreasing. To date, MICA has been able to control their overhead costs. Reinsurance costs have significantly risen. Reinsurance costs are the costs for reinsuring what the primary carriers purchase to cover limits in excess of their retention. Reserves have increased, potential dividends have decreased, and claims indemnity and expenses have risen.

Mr. Malpiedi referred to several graphs and charts in the handout which shows the outcome of malpractice cases closed in 2001 and how they affected MICA. However, other things also affected the industry: 1) price competition resulted in inadequate premium and inadequate reserves for many companies; 2) growth in poorly understood markets added to loss severity; 3) stock companies were unable to generate the rate on equity sufficient to maintain stock prices; and 4) change in tort reform laws in some states created loss costs not contemplated in the rates.

Senator Cirillo asked what percent of cases are responsible for the increase of losses because of class action lawsuits. Mr. Malpiedi replied that he is unable to answer that question; however, he is aware that more defendants have been added to cases they have encountered. A jury's rendering of high dollar settlements drags many of the other losses to similar levels.

Mr. Cronberg questioned if rates are set based on a physician's individual practice. Mr. Malpiedi replied that they use Arizona specific data to set rates, reviewing the total loss pool by specialties.

Ms. Hughes mentioned that the Committee has heard from Dr. Rowe that her insurance had increased from $35,000 to $120,000 which is a dramatic increase. She questioned if MICA's losses are so high that such a huge increase was applied to the doctors across the board. Mr. Malpiedi replied that Dr. Rowe's insurance is with another carrier and he cannot address the issue. He indicated that the Department of Insurance (DOI) approves and oversees MICA's rates.

Mr. Cronberg asked if there are some type of controls in place monitoring how much a carrier can increase their premiums. Mr. Malpiedi replied that DOI evaluates the company's actuarial studies, reviewing any rate changes.

Dr. Grogan questioned if MICA anticipates any rate increases in malpractice insurance in the next five years in the rural areas. Mr. Malpiedi answered that he feels the overall rates will be going up. He indicated that they do not have a differentiation between rural or urban.

Representative Poelstra referred to the losses from lawsuits and questioned if there is any data available. Mr. Malpiedi replied that he could provide that information after the meeting.

P te Wertheim, House of Representatives Health Committee Analyst, distributed a handout (Attachment 3) regarding the overview of malpractice laws in Arizona and other

states. He provided a brief overview of Arizona laws, tort reforms from other states, and other alternatives to tort reforms. He pointed out that there are several types of tort reforms: 1) damage caps; 2) periodic payments; 3) abolition of collateral source rule; 4) limiting attorney contingency fees; and 5) abolition of joint and several liability. Some alternatives to tort reform include: 1) second generation reform; 2) arbitration; 3) review panels for pretrial screening; 4) insurance reform; 5) patient compensation funds; 6) joint underwriting associations; and 7) many other proactive factors.

Beverly Mahlmann, Chief Executive Office, Arizona Family Care Associates, explained that her association is a group of multispeciality physicians who serve Douglas, Bisbee, and Sierra Vista. The malpractice crisis hit the group in September, 2001. Their carrier left the State and they had to go to another carrier - American International Group (AIG). The previous premium was approximately $400,000; however, the new premium was approximately $900,000 and they had to pay a "tail coverage" of $800,000. She indicated that without tort reform, the availability of health services are in jeopardy. She also pointed out that Arizona businesses rely on "snowbirds." Without sufficient healthcare, "snowbirds" will no longer come to Arizona which would be a great loss of revenue to the State. She stressed that as long as there are no controls over payouts in lawsuits, the malpractice crisis will continue. She added that her organization worked diligently on eliminating risks; however, that is not enough. The issue is how much is paid out in a lawsuit. The current system provides an incentive to file a lawsuit because in most cases, something is paid to the patient. She indicated that she will be disappointed if healthcare becomes unavailable to Arizona citizens because of the lobbyists. Other states have found a way to work around that issue and Arizona should also.

Ms. Hughes asked for the full name of the organization's carrier. Ms. Mahlmann replied that it is Lexington Insurance.

Bruce Hancock, Medical Indemnity Group, noted that he has been in the insurance business for 27 years and his practice is dedicated solely to the healthcare community. Three years ago there were 11 malpractice insurance carriers in the state; today there are three: 1) MICA is the predominate carrier; 2) Medical Protective which is owned by General Electric; and 3) The Doctors Company. He indicated that MICA has done one thing better than the other carriers which is to provide a stable rate structure.

Mr. Cronberg questioned what happens to a doctor who cannot find malpractice insurance. Mr. Hancock replied if a doctor has one claim, they might be able to obtain coverage from a substandard company.

Mr. Hancock noted that a number of current claims are filed because prenatal care is not being provided and if a problem occurs, the emergency room doctor is held liable.

Mr. Carland indicated that it was mentioned that carriers will not take a doctor with a single claim. He asked if that was true with MICA. Mr. Hancock replied that MICA looks at the individual doctors on a case-by-case basis.

Ms. Hughes asked that if a patient is served by a FQHC and something goes awry, who does that patient sue. Mr. Hancock replied that he does not know.

Representative Poelstra asked that staff research that issue and provide information to the Committee.

Vista Brown, Legislative Liaison, DOI, testified that rates are regulated under an open competition system. The statutory standard for these rates is that they cannot be excessive, inadequate, or unfairly discriminatory. By statute, DOI cannot find rates excessive unless they first find that there is not a competitive market for the rates. The only remedy would be to have prior approval of those rates. She also pointed out that they do have a law that allows DOI to create this thing which functions like an insurance company when there is no private market for that line of insurance. That law was opined by the Attorney General's (AG) office to be unconstitutional. A taskforce was formed to review these issues and determined that there are still some constitutional and practical problems about the funding mechanism within that law. She indicated that DOI is currently seeking an AG's opinion regarding that law.

Senator Arzberger suggested that the Committee establish two working groups. One to review the malpractice law options and recommend changes to meet the Committee's goals. The second working group will meet with doctors and hospital administrators to recommend changes that will improve the Committee's goals. Dr. Carland and Representative Poelstra will form the first working group and Ms. Hughes and Representative Poelstra will form the second working group. Senator Arzberger also ask if Representative Cannell would provide input to each of the working groups and asked if anyone else wants to participate, it would be greatly appreciated.

Senator Arzberger pointed out that the Committee's goals are to determine a method to reduce the loss of doctors and healthcare access in rural areas and to improve the rural areas ability to meet the obstetrical needs locally.

There being no further business, the meeting was adjourned at 11:55 a.m.

Respectfully submitted,

Carol Dager

Carol Dager
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

9/18

Rural Physicians Study Committee

Jim Dickson, CEO
Copper Queen Hospital
Bisbee, Arizona
September 18, 2002

Physician Shortage

- The majority of Rural Arizona is classified as a Medically Underserved Area and Healthcare Professional Shortage Area failing to meet minimum federal standards for patient physician ratios

Bureau of Health Professionals & Graduate Medical Advisory Committee Recommends The Following Ratios

(Chart 1)

	1990	2000
Arizona Population	3,700,000	5,100,000
Physicians	7,306	9,474
Phys/100,000 Pop	198	185
Bureau Health Professionals Standard	230.9	230.9
Graduate Medical National Advisory Committee	194.6	194.6

Hospital Owned and Supported Practices

Refer to attachment B

Environmental Negatives

- Uninsured
- Managed Care
- Malpractice

Goldwater Institute

Arizona Issue Analysis 165

October 2001

1. *Uninsured Rate*—the national percentage of uninsured is 16 percent. Arizona stands out with a 23 percent uninsured rate. This means that almost one in four patients will not have insurance—a significant cause of uncompensated care. It is tied with New Mexico in second place. Texas leads the nation with a 24 percent uninsured rate (but it ranks 29th in HMO penetration, at 19 percent, leaving more room for cost shifting of uncompensated care to those with regular insurance). Nevada has 20 percent uninsured, and California has 21 percent uninsured. New York has 17 percent uninsured. Florida's rate is 19 percent. (Data for 1997-99.)

Additional Population Cared For By Hospitals & Physicians On The Border And In Tertiary Hospitals

(Chart 2)

	Tucson Sector	Apprehension
1992	71,036	284,144
1993	92,369	369,476
1994	139,473	557,892
1995	227,529	910,116
1996	305,348	1,221,392
1997	272,397	1,089,588
1998	387,406	1,549,624
1999	470,449	1,881,796
2000	616,346	2,465,384
2001	449,675	1,798,700
2002	309,450	1,237,800

Estimated cost for treatment of uncompensated care which does not include fiscal impact on private physicians

Hospital Charges Related to Treating Undocumented Immigrants
A Survey of 16 Arizona Hospitals Covering the Period of February 1 Through April 30, 2001

	Three Month Reported Data:				Annualized Results:			
	Inpatient	Outpatient	Unknown	Total	Inpatient	Outpatient	Unknown	Total
Charges	$ 9,672,730	$ 866,116	2,380,793	$ 12,870,640	$ 38,690,956	$ 3,362,464	8,999,140	$ 51,062,560
								44,100,176
Uncompensated Charges								
Mode of Arrival:								
Ambulance	90	161		251	360	644		1,004
Helicopter	31	1		32	124	4		128
YMA-h	200	598		798	800	2,224		3,024
DPS	4	5		9	16	20		36
Border Patrol	3	-		3	12	-		12
Fire Department	7	5		12	28	20		48
Other	6	7		13	24	28		52
Unknown	175	264	306	715	500	1,136	1,224	2,860
Total	496	1,018	306	1,781	1,864	4,078	1,224	7,164

Notes:

Reporting hospitals include Banner Health System, Benson Hospital, Chandler Regional Hospital, Copper Queen Community Hospital, Carondelet hospitals, John C. Lincoln Hospital - North Mountain, Maricopa Integrated Health System, Maryvale Hospital Medical Center, Phoenix Children's Hospital, St. Joseph's Hospital and Medical Center, Tucson Medical Center, & University Medical Center.
In all 16 hospitals reported.

On average the reporting hospitals were reimbursed 15% of the total charges with the majority of the reimbursement coming from the AHCCCS, IHS program.

Managed Care

Goldwater Institute

Arizona Issue Analysis 165

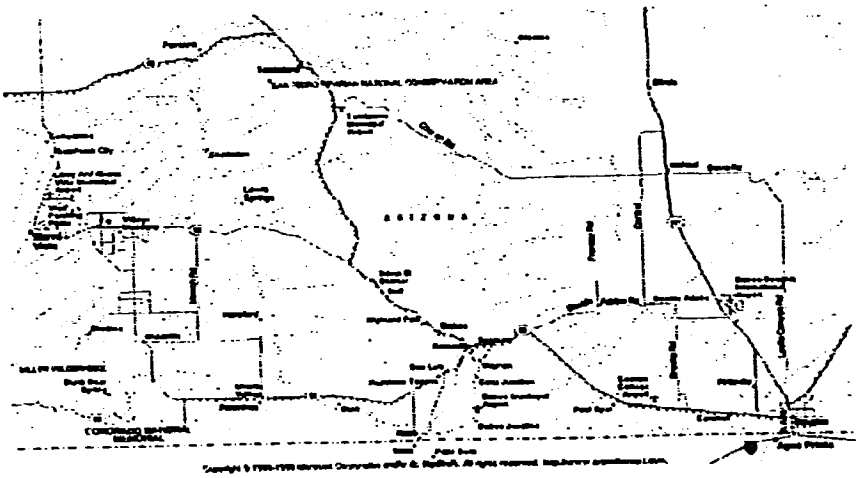
October 2001

1. *HMO Penetration Rate*—Arizona's HMO penetration rate is 31 percent. Arizona ranks 17th in the US in HMO penetration, tied with Florida and New Jersey. The national HMO penetration rate is 30 percent. California leads the nation in HMO penetration (54 percent). Massachusetts (53 percent), Connecticut, Maryland, Oregon, and Colorado are 2nd through 6th respectively, all having greater than 40 percent penetration. New Mexico is 7th with 38 percent penetration, and Nevada is 25th, with 23 percent penetration. These findings reveal nothing that suggests Arizona has an HMO penetration rate at any major variance with much of the country. It certainly compares well with neighboring states or states with similar attributes. The data are for the year 2000.

Malpractice

- The Malpractice Insurance Market in Arizona is impacted by the of losses incurred in the re-insurance market and 9/11.
- Over 40% of Medical malpractice Insurance carries stopped providing coverage in Arizona.
- Hospitals and Physician are scrambling for malpractice insurance.
- Had to Pay Huge Sums for "Tail Coverage". – amt of $ you pay if you leave your practice (paid upfront before you leave).
- 80% of the Physicians in Cochise County lost their Malpractice Coverage.
- Several companies refuse insurance coverage for one malpractice claim regardless of the disposition of the claim.

Southeastern Arizona - Bisbee



Southeastern Cochise County

- The Hospitals and Physicians who provide care in isolated rural areas are integrated. The Hospital and Physician welfare and survival depend on each other. If the negative environment for physicians continue it cannot bode well for the Hospitals.
- During the past two years, the Hospitals have had to close their Obstetrics Departments, Long-term care facilities as well as reductions in other services. These changes were made due to extensive resource utilization in treating uncompensated care
- The malpractice crisis (the withdrawing of carriers) hit Southeastern Cochise County exceptionally hard. Over 80% of the physicians were affected in Sierra Vista, Bisbee and Douglas. The physicians had to scramble to obtain coverage.

Copper Queen Hospital

reduction in services

Southeastern Cochise County

- Finally one insurance carrier picked up the physicians. The name of the carrier is AIG. The physicians involved had to pay coverage tails from $100,000 to $1,000,000.00. They experienced cost increases from 100 to 500%.
- The instability coupled with inability to raise revenue has now placed the surgery programs in Southeastern Cochise County in jeopardy. There are two remaining General Surgeons on the eastern side of Cochise County. Both of these surgeons have practiced in this area for over 15 years. They have now encountered significant increases in malpractice insurance. It has been indicated to me that they are considering stopping or changing practice patterns

Southeastern Cochise County

- Both Southeastern Arizona Medical Center and Copper Queen Community Hospital have experienced severe drops in inpatient census due to loss of, or physicians changing their practice patterns.
- With the reduction of physician availability both Hospitals have experienced inordinate growth in the use of their Emergency Rooms.
- With the reduction of physician availability both Hospitals have experienced inordinate growth in the use of their Emergency Rooms.

over last yr, 250/month ↓ +550/month

Recommendations

- Tort Reform- The legal system is preying on the healthcare system and in the long run will cause more harm for lack of care. We must amend the state constitution through referendum and implement the various aspects of tort reform as indicated by the GAO study attachment C . If it takes five referendums, we must fight this battle or see the virtual collapse of fee for service independent healthcare in rural Arizona.
- Preserve AHCCCS Funding- It is incredibly important that that due to the high incidence of uninsured and uncompensated care that a modicum of payment be maintained.

Recommendations → federally qualified healthcare clinics

- Enhance Primary Care Through FQHCs The federal governments policies of not protecting the Border and allowing for compassionate healthcare entry have placed the current healthcare system in crisis. The federal primary care cost reimbursement systems need to be enhanced. This effort must be reflected by the State of Arizona's willingness to fund these types of programs. These clinics have the advantage of being malpractice sheltered and receive additional federal dollars for operations. Since most of rural Arizona is MUA/HPSA they qualify for these types of programs

- Continue Lobbying the Federal Government – We must continue to lobby the Federal Government to accept the financial responsibility for their policies. We need to press for; more immigrant healthcare compensation, recognition that we are the healthcare provider for Northern Mexico and deserve compensation and finally control the Border with a rational guest worker program

Thank You

Presentation to the Rural Physicians Study Committee
By James J. Dickson, Administrator/CEO
Copper Queen Community Hospital
9-18-02

1. Overview

Rural healthcare in Arizona is facing a challenge for survival. The majority of rural Arizona is classified as Medically Underserved Area (MUA's) and a Healthcare Professional Shortage Area (HPSA's) failing to meet minimum federal standards for patient physician ratios. The Bureau of Health Professionals and Graduate Medical Advisory Committee recommends the following ratios (see attachment a):

Chart 1

	1990	2000
Arizona Population	3,700,000	5,100,000
Physicians	7,306	9,474
Phys/100,000 Pop	198	185
Bureau of Health Professionals Standard	230.9	230.9
Graduate Medical National Advisory Committee	194.6	194.6

Arizona not only suffers from an undersupply of physicians but a mal-distribution with many of the rural areas having no physician and the urban areas well supplied.

Hospital Subsidized Physician Practices

To solve this dilemma many of the rural Hospitals have engaged in physician practice subsidy and owning / managing physician practices. In spite of these efforts there remains an acute shortage of healthcare providers in rural areas. Hospital's declining reimbursement and federally mandated care (Emergency Medical Treatment and Labor Act) have reduced Hospitals disposable surpluses (see attachment B). The plain simple hard fact is that with sparse populations the healthcare dollars available to support physician practices are not available. This has made Physician recruiting and retention a very costly and a futile practice.

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Environmental Negatives

Uninsured and Uncompensated Care

The state of Arizona has a disproportionate share of uncompensated care as compared to other states as a result of individuals lacking insurance (attachment A).

4. *Uninsured Rate*—the national percentage of uninsured is 16 percent. Arizona stands out with a 23 percent uninsured rate. This means that almost one in four patients will not have insurance—a significant cause of uncompensated care. It is tied with New Mexico in second place. Texas leads the nation with a 24 percent uninsured rate (but it ranks 29th in HMO penetration, at 19 percent, leaving more room for cost shifting of uncompensated care to those with regular insurance). Nevada has 20 percent uninsured, and California has 21 percent uninsured. New York has 17 percent uninsured. Florida's rate is 19 percent. (Data for 1997-99.)

In addition to the high levels of non-insured care encountered with resident Arizonans, Arizona's Hospitals and Physicians are forced to care for migratory populations because of our proximity to the Border with Mexico. This population is not counted for in the statistics mentioned above. This situation is as a result of two federal policies: funneling immigration through Arizona away California and Texas, and compassionate entry for healthcare for Mexican Nationals.

It is difficult to arrive at an exact number of immigrants that pass through the border of Cochise County because the number of actual immigrants far exceeds the apprehended immigrants. Based on Immigration and Naturalization statistics the rate of apprehension to those not apprehended is a between a 1-4/1-5 ratio. This is based on INS estimate that they apprehend fewer than 20- 25% of the people immigrating to their destinations up North. Chart 2 demonstrates the estimated additional populations cared for by Hospitals and Physicians on the Border and in tertiary Hospitals.

Chart 2

	Tucson Sector Apprehensions	Not Apprehended.
1992	71,036	284,144
1993	92,369	369,476
1994	139,473	557,892
1995	227,529	910,116
1996	305,348	1,221,392
1997	272,397	1,089,588
1998	387,406	1,549,624
1999	470,449	1,881,796
2000	616,346	2,465,384
2001	449,675	1,798,700
2002	309,450	1,237,800

The shift in Federal policy has also caused unanticipated and permanent changes in Sonora Mexico. As immigration traffic increased across the Arizona section of the U.S. border, Sonora Mexico has experienced phenomenal population growth. This is especially true in the towns of Agua Prieta and Naco, Mexico. The population of Agua Prieta has grown from 40,000 to +80,000 in a ten-year period. Some population estimates for Agua Prieta approach 140,000. The population of Naco has grown from 10,000 to +25,000. It is difficult to get an exact figure because of the their transient nature of this population. It has turned these small peaceful towns into centers for trade in illegal immigration and drugs. This growth has had a virtual "boomtown" effect on these communities. The Compassionate entry policy of the Federal government allows any individual who needs healthcare to "pass" through the Border unimpeded and by federal law (EMTALA) Hospitals and Physicians are required to treat presenting to Emergency Services for care.

These population increases, whether migrating or residing in "boomtowns" south of the Border place a huge and un-anticipated on demand on healthcare services in Southern Arizona. It has especially affected the Emergency Medical System. One Trauma Center in Tucson announced that they were going to close because of their inability to sustain their huge losses (see attachment C by the AzHHA Study on losses by Hospitals). These losses are due mainly to mishaps that occur in apprehensions and Mexican national who are admitted to the United States for healthcare. These losses omit the portion of uncompensated care that Physicians provide in Emergency Rooms and their offices.

Managed Care

Arizona has one of the highest percentages of managed cared patients in the nation (attachment A).

1. ***HMO Penetration Rate*—Arizona's HMO penetration rate is 31 percent. Arizona ranks 17th in the US in HMO penetration, tied with Florida and New Jersey. The national HMO penetration rate is 30 percent. California leads the nation in HMO penetration (54 percent). Massachusetts (53 percent), Connecticut, Maryland, Oregon, and Colorado are 2nd through 6th respectively, all having greater than 40 percent penetration. Mew Mexico is 7th with 38 percent penetration, and Nevada is 25th, with 23 percent penetration. Theee findings reveal nothing that suggests Arizona has an HMO penetration rate at any major variance with much of the country. It certainly compares well with neighboring states or states with similar attributes. The data are for the year 2000.**

The adverse effect of managed care is the amount of paper work and clearance for care. In addition it usually means physicians accept discounted payment scenarios and cannot recoup costs through a fee for service market system.

Malpractice

Physicians and Hospitals in the Arizona have been severely impacted by the current malpractice dilemma/crisis in Arizona. In the fall of 2001, 40% of the malpractice insurance carriers announced that they were ceasing to underwrite coverage in Arizona. This decision was based on the re-insurance market crisis and the adverse risk environment caused by Arizona's lack of Tort reform. This left 40% of Hospitals and Physicians scrambling to obtain coverage in an adverse insurance market. The remaining companies were highly selective as to who they would underwrite, in some instances physicians with a history of one law suit were denied. The impact of this caused physicians to incur malpractice increases of 200 to 500%. The secondary financial impact was the physicians were forced to purchase devastating tail coverage policies.

Individuals and entities debate the cause of the malpractice situation. The debate is that Insurance Companies are at fault for not charging enough premiums. There is also much discussion that this is part of a cycle that repeats itself. One thing is for certain, that there is a significant difference in the healthcare market today. Physicians are faced with the negative environment caused by increasing uncompensated and uninsured care. They are not capable of cost transference as in the past.

Southeastern Cochise County

Southeaster Arizona has experienced the adverse conditions that prevail across rural Arizona in general. The Hospitals and Physicians who provide care in isolated rural areas are integrated. The Hospital and Physician welfare and survival depend on each other. If the negative environment for physicians continue it cannot bode well for the Hospitals.

The areas of Elfrida, Douglas and Bisbee constitute the Southeastern side of Cochise County. Each of the communities is designated as MUA. MUP, or HPSA. They also face the brunt of the immigration surge and compassionate care entry policies of the Federal Government.

During the past two years, the Hospitals have had to close their Obstetrics Departments, Long-term care facilities as well as reductions in other services. These changes were made due to extensive resource utilization in treating uncompensated care. The closure of the OB services was directly related to the malpractice crisis.

Presentation to the Rural Physicians Study Committee
By James J. Dickson, Administrator/CEO
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The malpractice crisis (the withdrawing of carriers) hit Southeastern Cochise County exceptionally hard. Over 80% of the physicians were affected in Sierra Vista, Bisbee and Douglas. The physicians had to scramble to obtain coverage. Many of the more desirable carriers refused to underwrite coverage if the physician had one malpractice claim. In some cases groups were denied coverage if one of the physicians in the group had experience when the other physicians had none. Finally one insurance carrier picked up the physicians. The name of the carrier is AIG. The physicians involved had to pay coverage tails from $100,000 to $1,000,000.00. They experienced cost increases from 100 to 500%. What is extremely precipitous is, one more September 11 or continuing adverse malpractice climate the sole remaining carrier will leave our market virtually uninsurable.

The instability coupled with inability to raise revenue has now placed the surgery programs in Southeastern Cochise County in jeopardy. There are two remaining General Surgeons on the eastern side of Cochise County. Both of these surgeons have practiced in this area for over 15 years. They have now encountered significant increases in malpractice insurance. It has been indicated to me that they are considering stopping or changing practice patterns. This would virtually eliminate another service to the patients of eastern Cochise County.

Both Southeastern Arizona Medical Center and Copper Queen Community Hospital have experienced severe drops in inpatient census due to loss of, or physicians changing their practice patterns. This also severely affected the cost of physician coverage in both Hospitals' Emergency Rooms. With the reduction of physician availability both Hospitals have experienced inordinate growth in the use of their Emergency Rooms. Both Hospitals have experienced close to 400% increase in uncompensated immigrant and compassionate entry care.

The implosion of the healthcare delivery system in southeastern Cochise County is an on going ever-increasing deteriorating situation.

Recommendations

1. **Tort Reform**- The legal system is preying on the healthcare system and in the long run will cause more harm for lack of care. We must amend the state constitution through referendum and implement the various aspects of tort reform as indicated by the GAO study attached. If it takes five referendums, we must fight this battle or see the virtual collapse of fee for service independent healthcare in rural Arizona.
2. **Preserve AHCCCS Funding**- It is incredibly important that that due to the high incidence of uninsured and uncompensated care that a modicum of payment be maintained.
3. **Enhance Primary Care Through FQHCs** The federal governments policies of not protecting the Border and allowing for compassionate healthcare entry have

placed the current healthcare system in crisis. The federal primary care cost reimbursement systems need to be enhanced. This effort must be reflected by the State of Arizona's willingness to fund these types of programs. These clinics have the advantage of being malpractice sheltered and receive additional federal dollars for operations. Since most of rural Arizona is MUA/HPSA they qualify for these types of programs.

4. **Continue Lobbying the Federal Government** – We must continue to lobby the Federal Government to accept the financial responsibility for their policies. We need to press for; more immigrant healthcare compensation, recognition that we are the healthcare provider for Northern Mexico and deserve compensation and finally control the Border with a rational guest worker program

ARIZONA STATE LEGISLATURE

RURAL PHYSICIANS STUDY COMMITTEE

September 18, 2002

Ronald E. Malpiedi, Vice President and COO, MICA

AMERICANS KNOW WE HAVE A PROBLEM – HCLA POLL

- 71% SAY SUITS ARE A REASON HEALTH COSTS ARE RISING (63% 12/99)
- 76% FAVOR CONTINGENCY FEE LIMITATIONS
- 73% FAVOR CAPS ON NON-ECONOMIC DAMAGES
- 78% FEEL PROVIDERS LEAVE PRACTICE DUE TO LAWSUITS

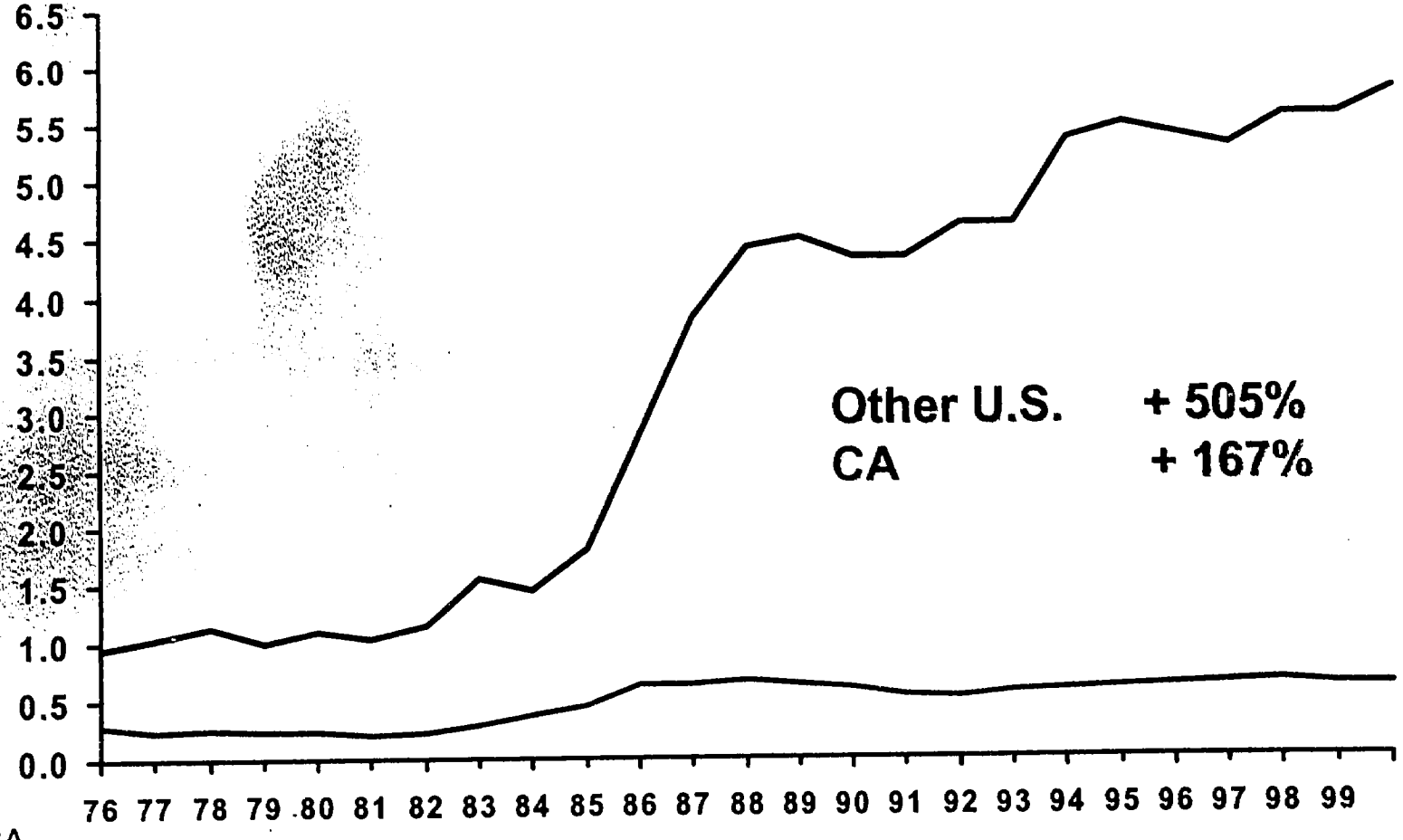
Source: Wirthlin Worldwide Poll, April, 2001

Health Care Liability Reform

- $250,000 cap on non-economic damages
- Collateral source offsets
- Periodic payment of future damages
- 1/3 year statute of limitations/repose
- Joint and several liability
- Contingency fee limits

Savings from MICRA Reforms

California vs. U.S. Premiums 1976 - 2000



MICA

$ Billions

Truths, Partial Truths & Falsehoods

Truth:

- Increasing loss costs are driving the rate increases

- Partial Truth:
  - "Insurers are increasing rates because of investment income losses, particularly their losses in the stock market."

Partial Truth:

- "Companies operated irresponsibly and caused the current problems."

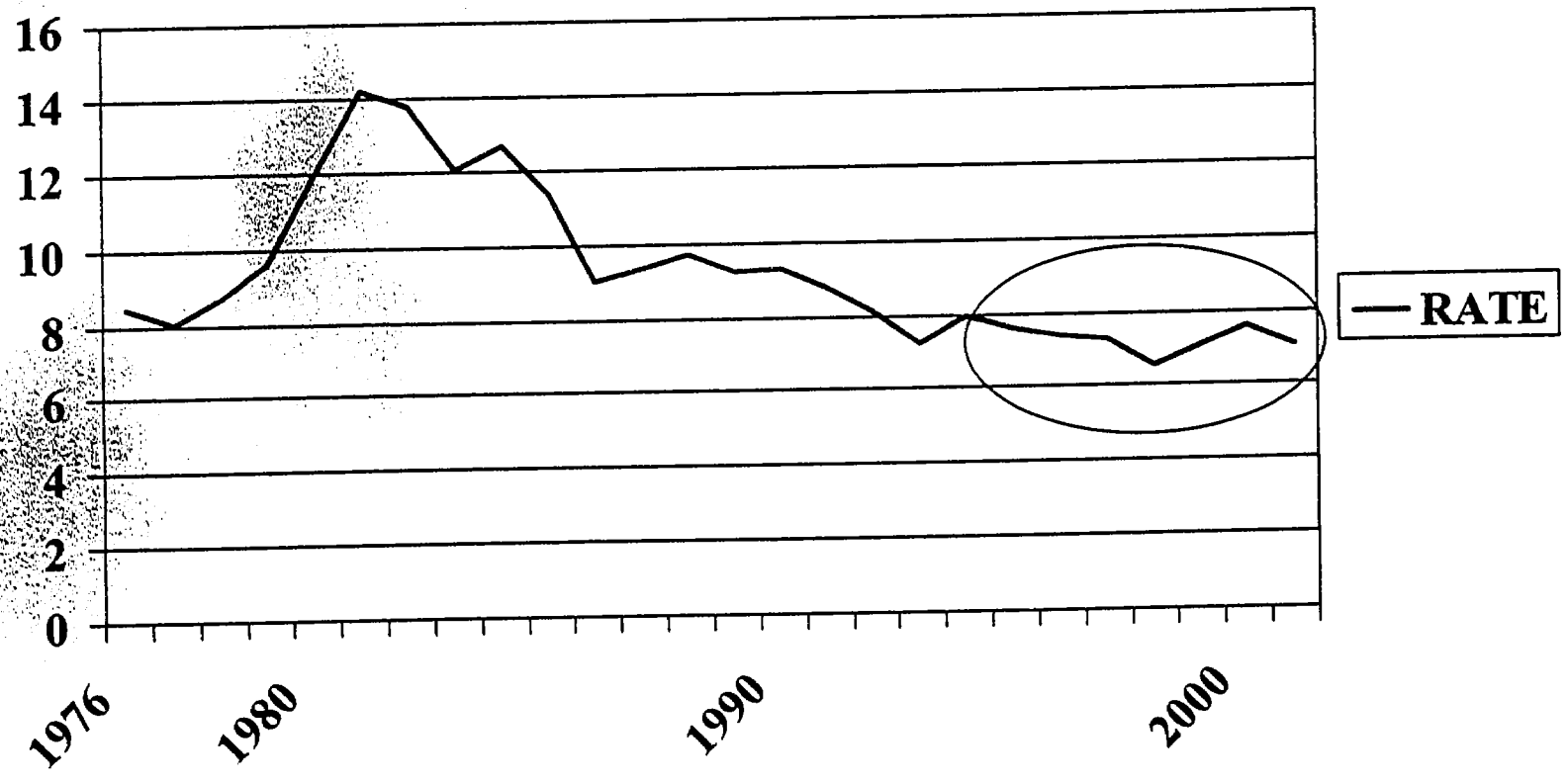
Partial Truth:

- "Companies are reporting losses to justify increasing rates."

False

- "Average payouts have stayed virtually flat for the decade."

MOODY'S LT AAA BONDS
Average Yield to Maturity



MICA Source: US Federal Reserve Bank 05/28/2002

Truths, Partial Truths & Falsehoods

Truth:

- Increasing loss costs are driving the rate increases

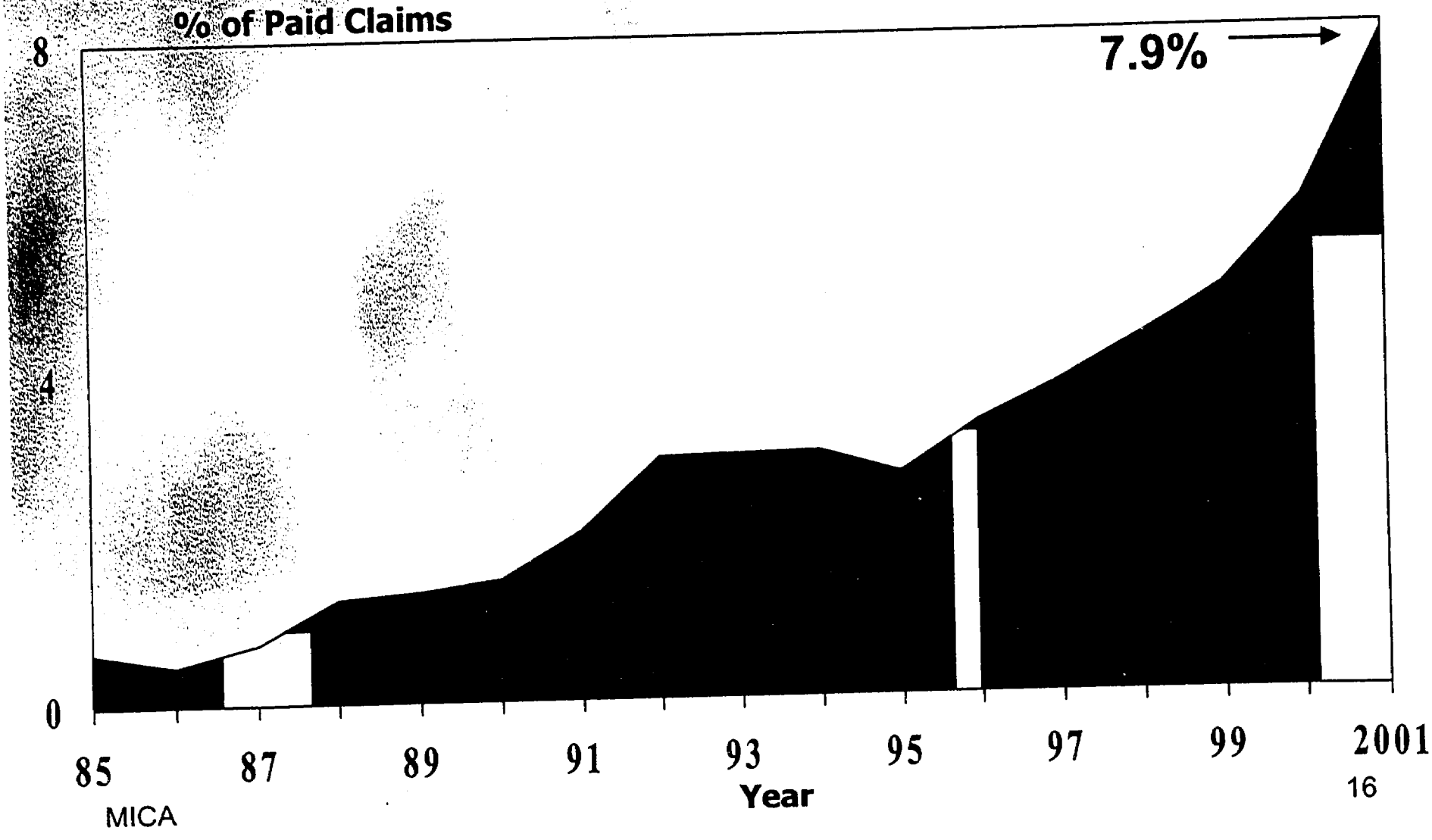
- Partial Truth:
  - "Insurers are increasing rates because of investment income losses, particularly their losses in the stock market."

But that is only part of the story …

- Price competition resulted in inadequate premium and inadequate reserves for many companies – notably PIE Mutual, PIC, PHICO,MIIX, Reliance, Frontier . . . And even St. Paul
- Growth in poorly understood markets added to loss severity
- Stock companies unable to generate ROE sufficient to maintain stock price may have shaved the reserves even further
- Change in state tort reform laws – Oregon – created loss costs not contemplated in the rates

PIAA Data Sharing Project

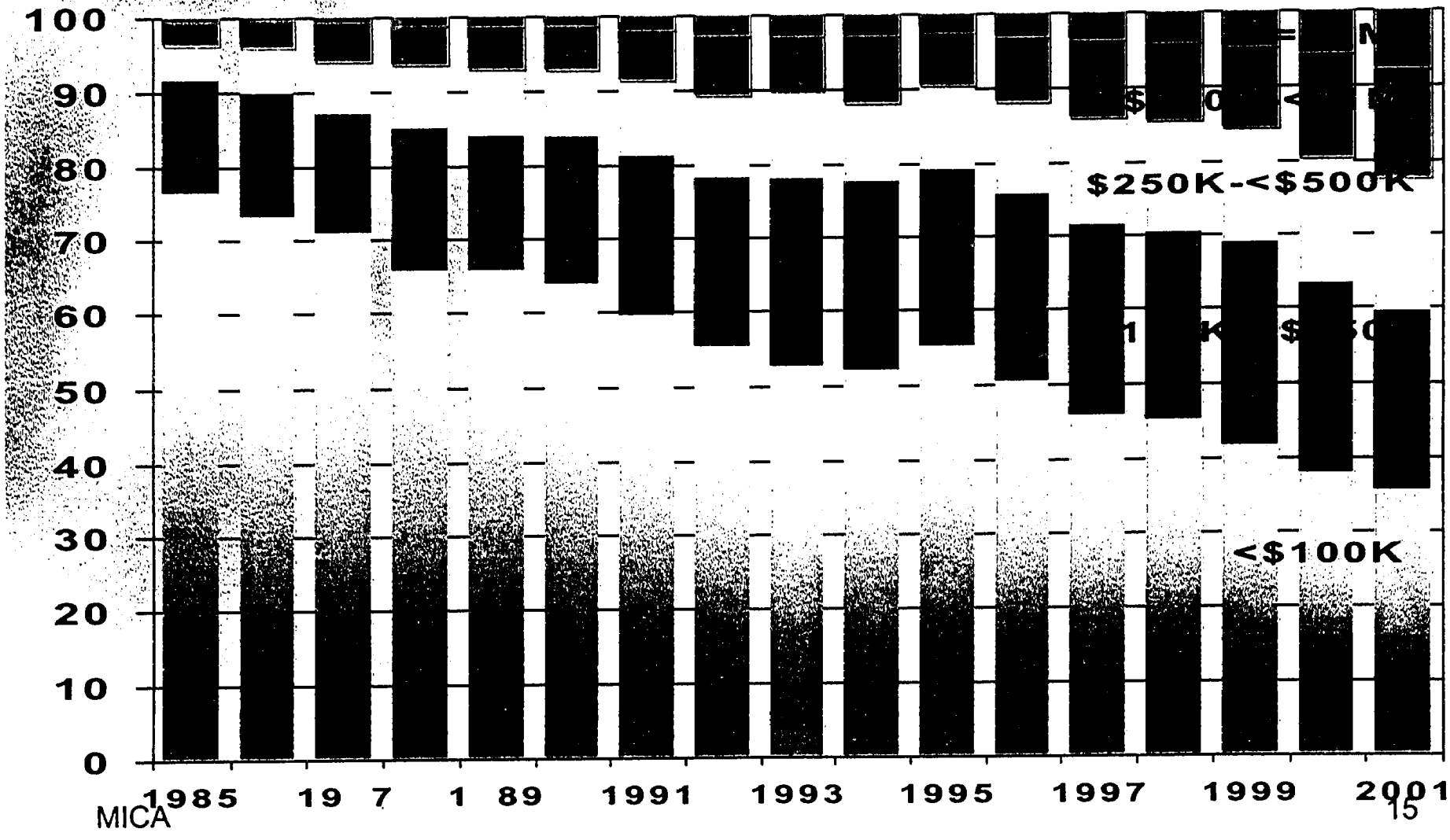
Claim Payments =>$1 Million



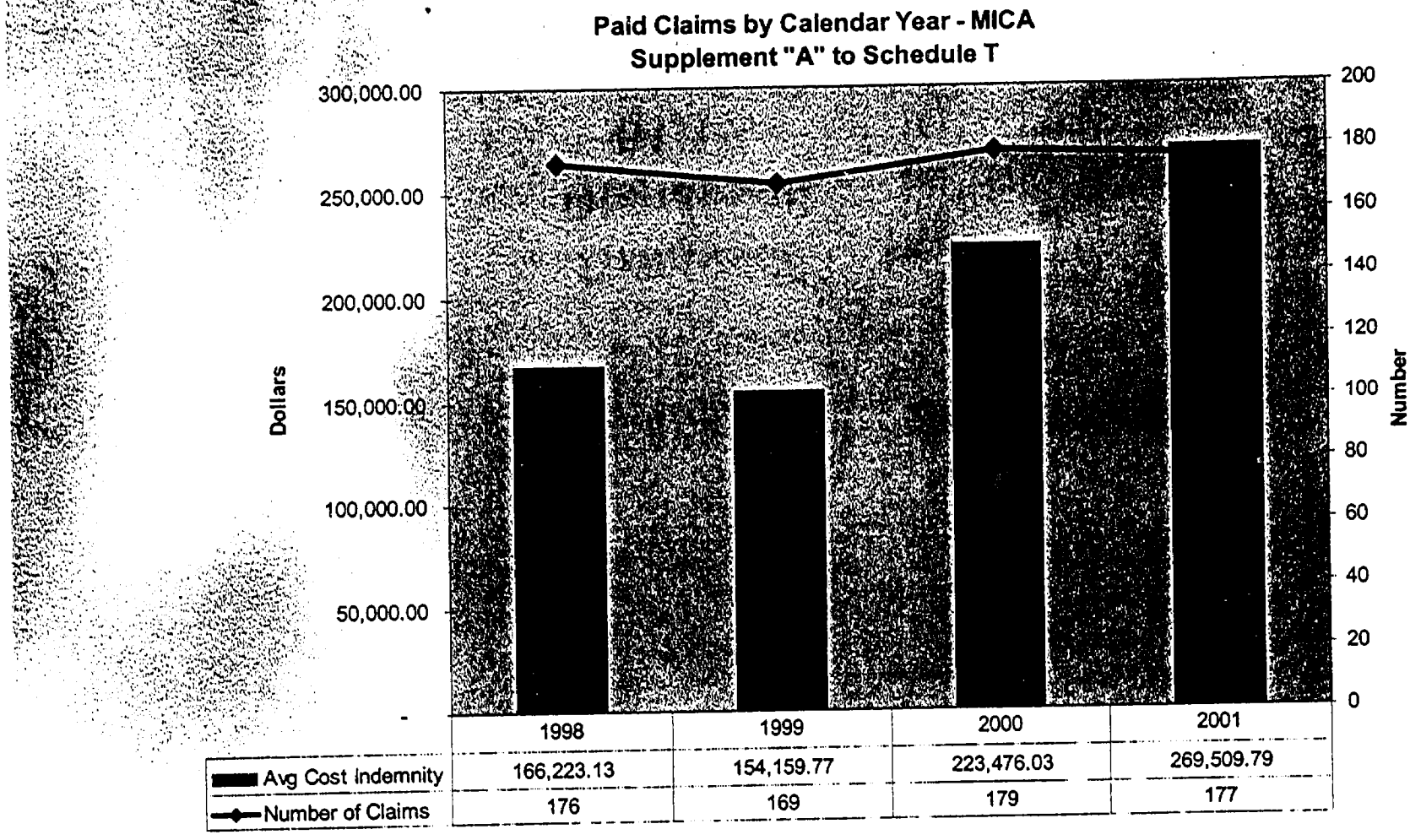
MICA

PIAA Data Sharing Project

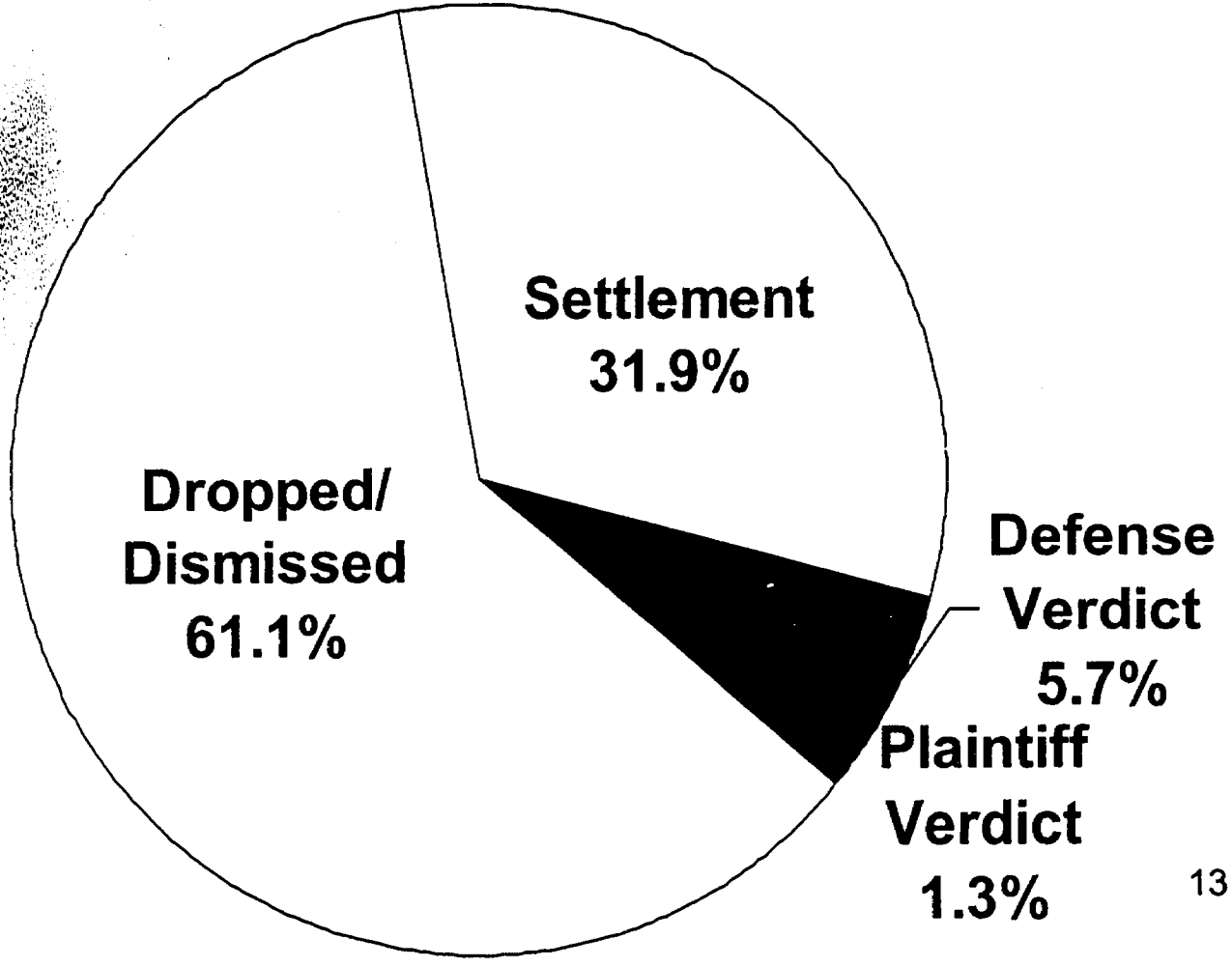
% of Paid Claims by Payment Threshold



MICA's Experience

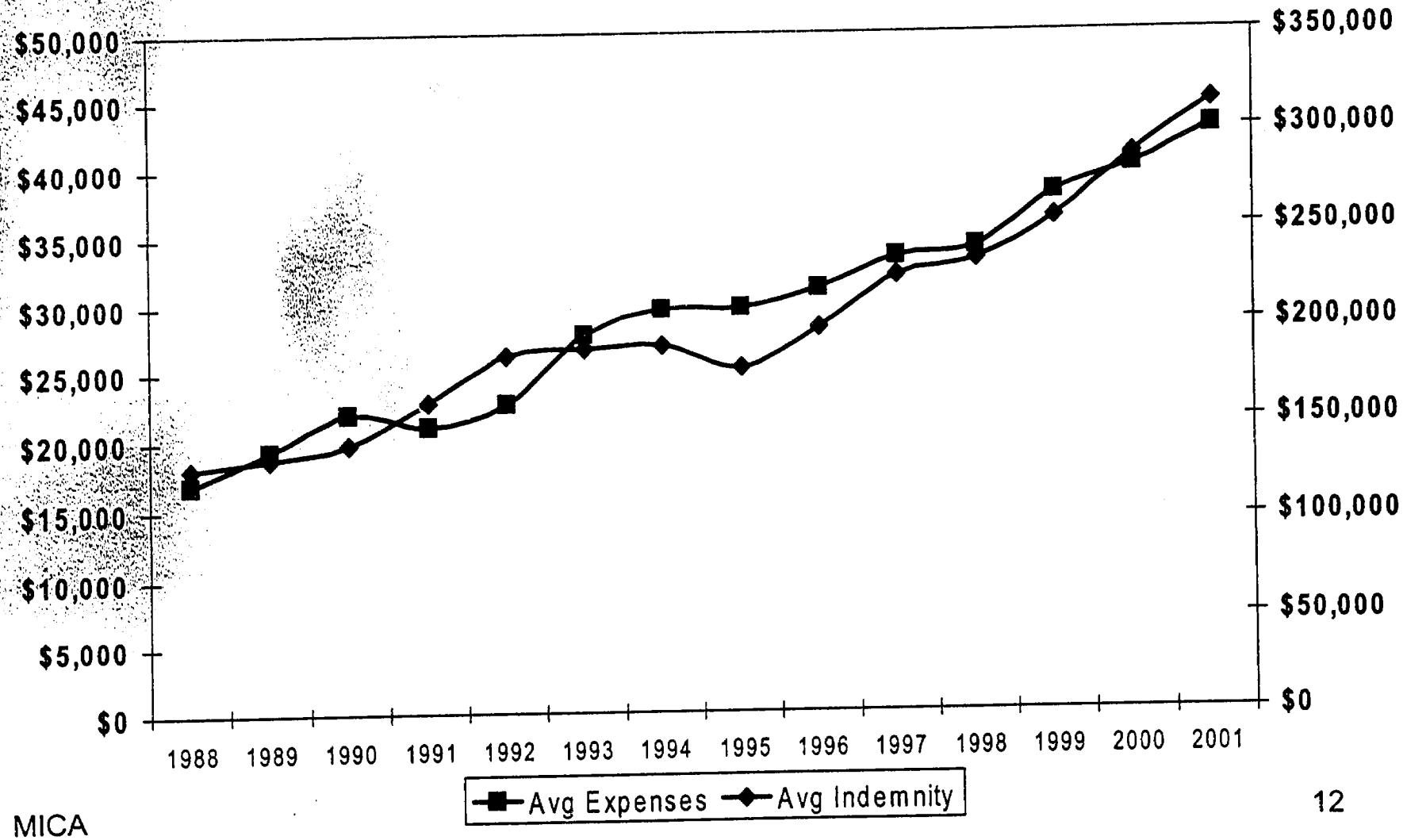


PIAA Data Sharing Project
Outcome of Malpractice Cases
Closed in 2001

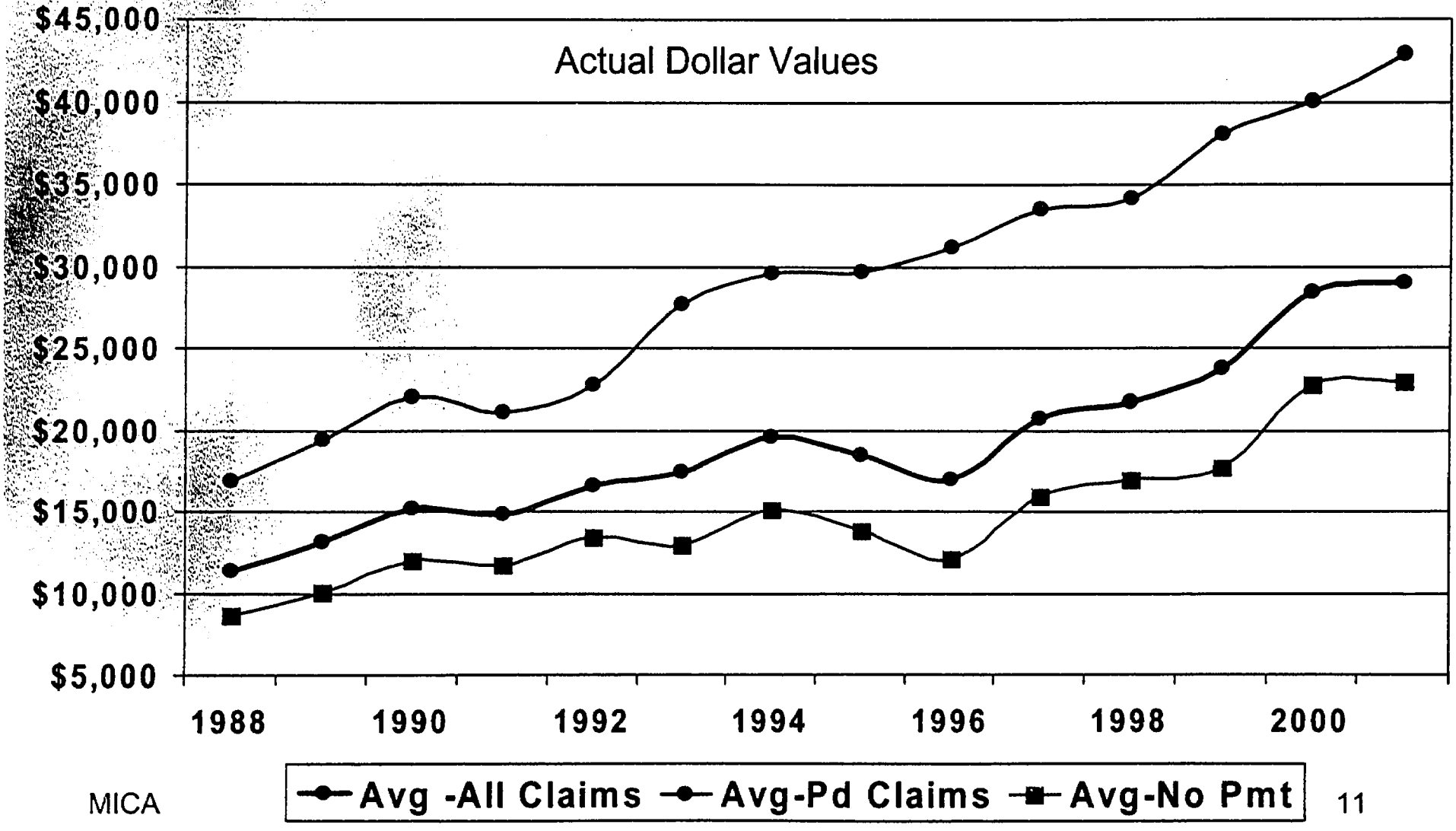


Avg Payments - Indemnity and Exp

PIAA Data Sharing Project

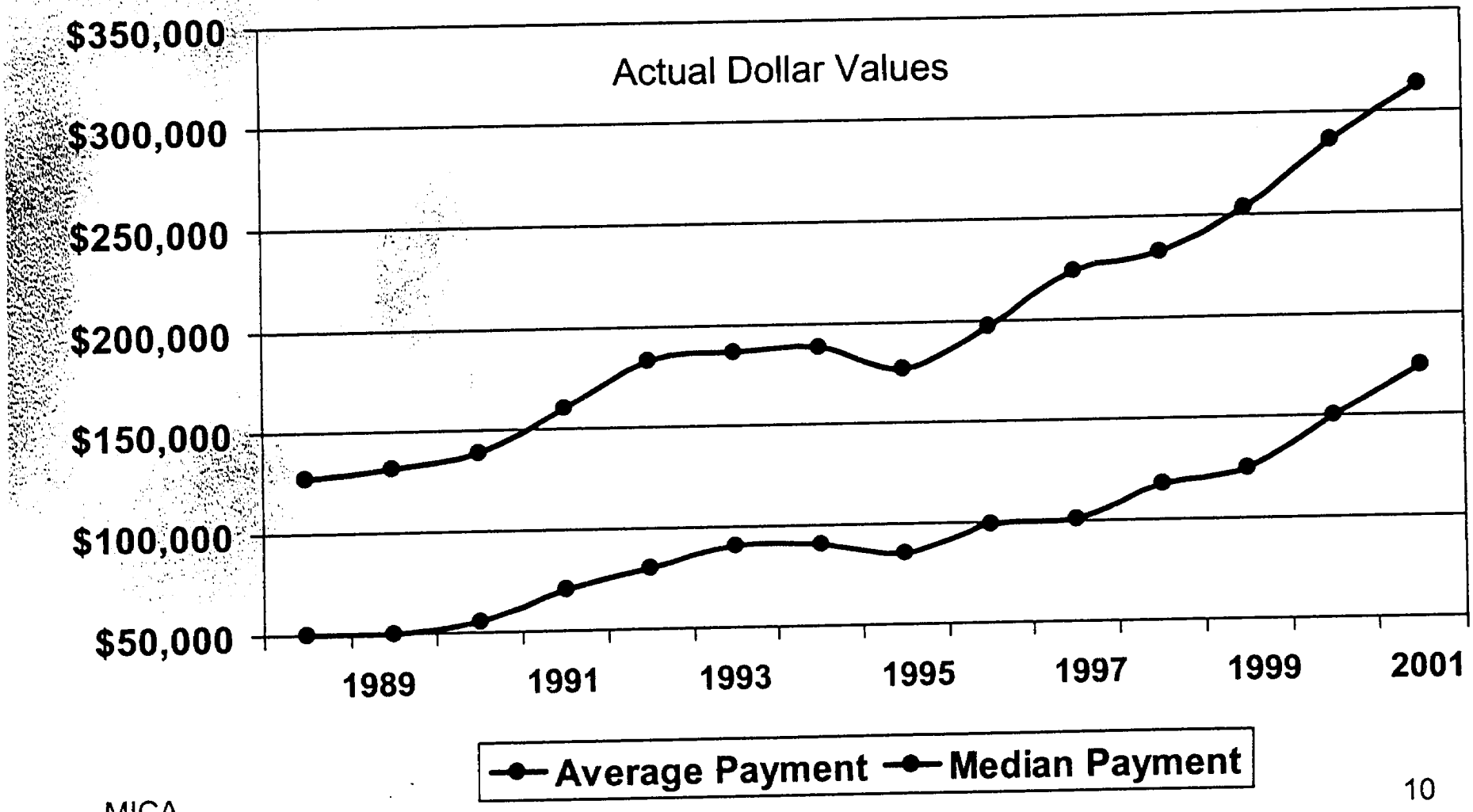


Average Expense Payment Values
PIAA Data Sharing Project



Physician Insurance Association of America

Average and Median Claim Payments
PIAA Data Sharing Project



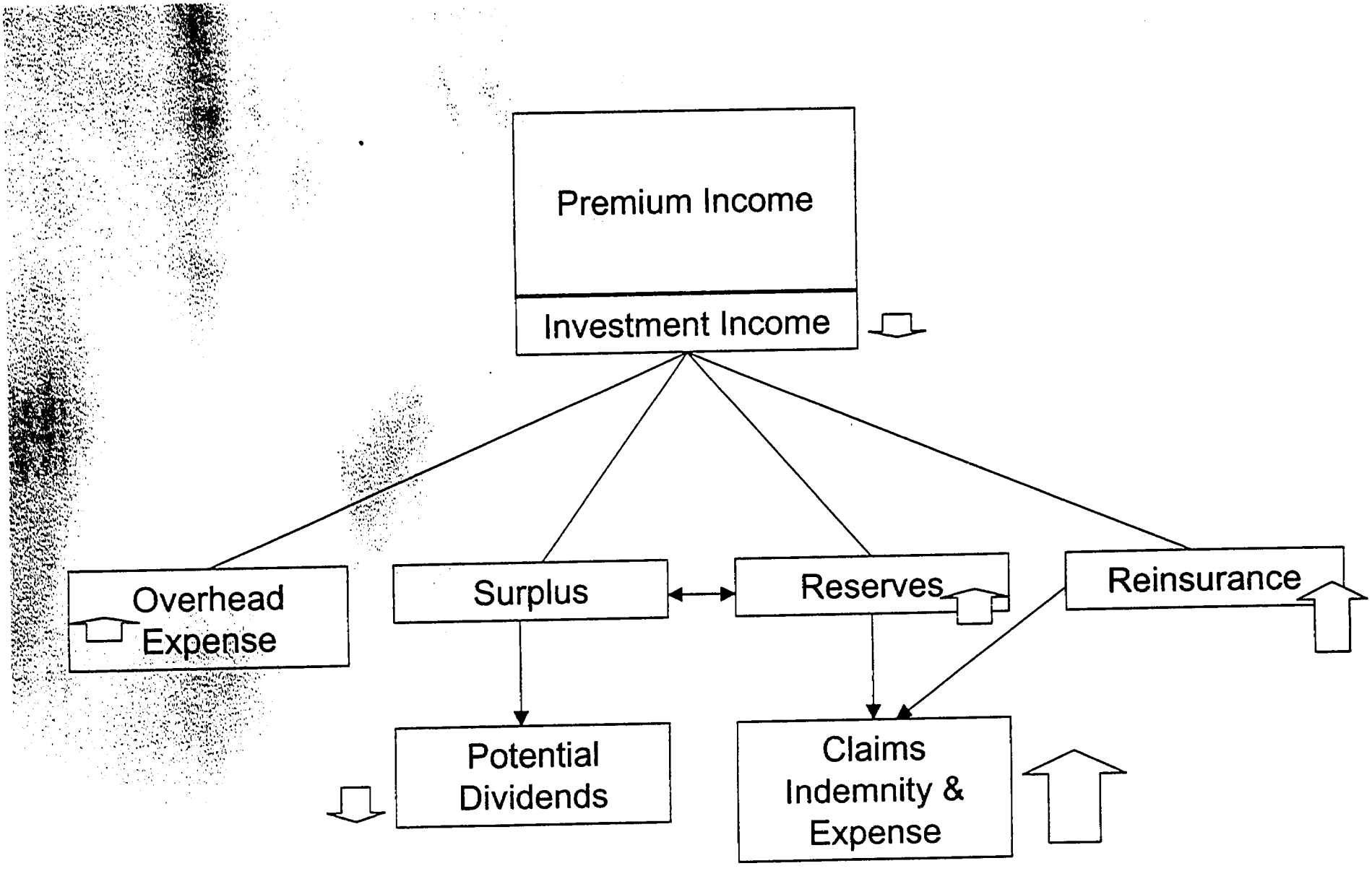
Basic Insurance & where we are

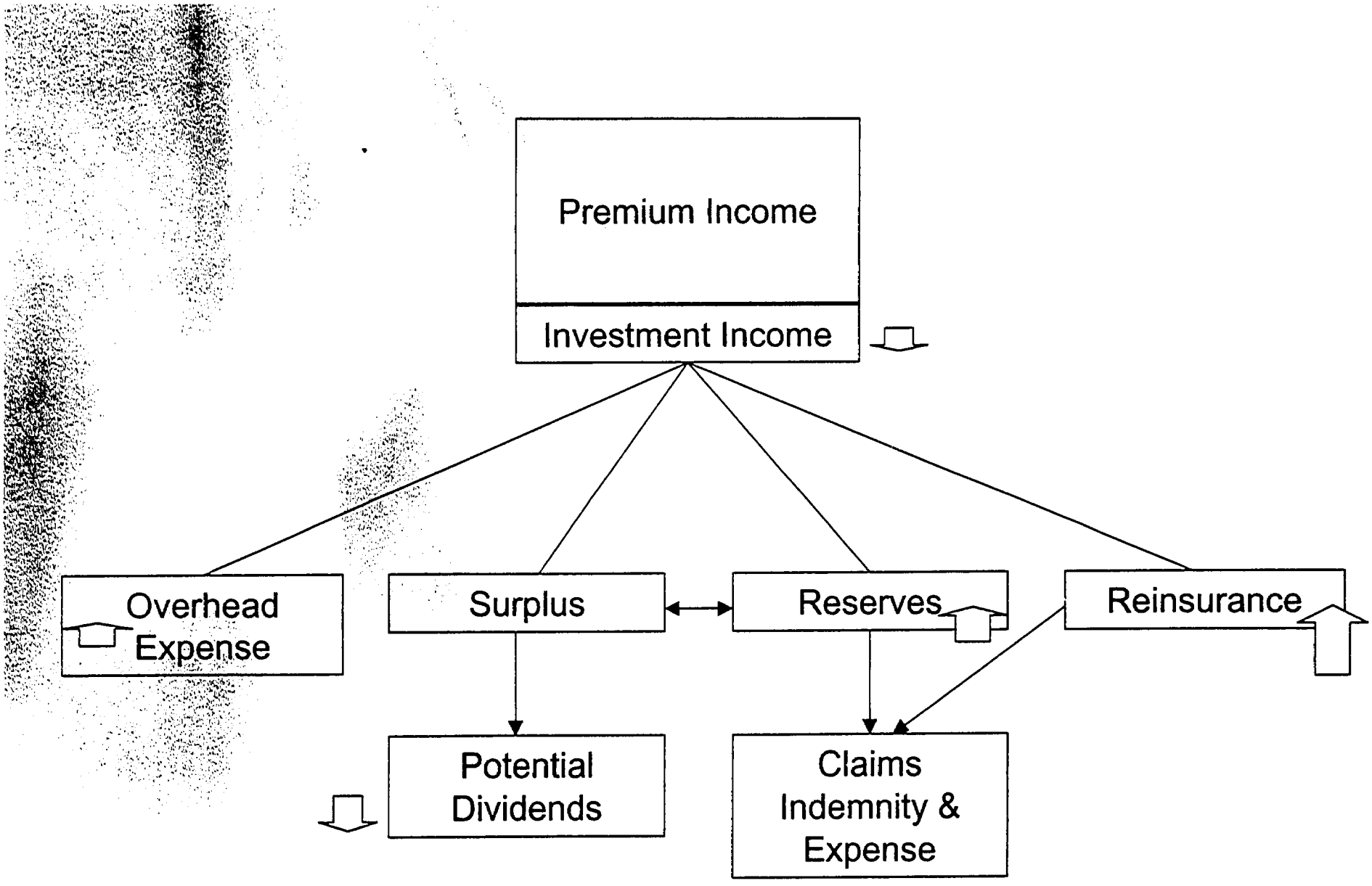
Loss severity is up . . . *Dramatically in regions such as Nevada, Pennsylvania, Florida, West Virginia and Texas* . . . As is the cost of defense

- Cost of Reinsurance is up *and* coverage is more restricted

Investment Income is down due to falling interest rates

Reserves are increasing in concert with loss severity increases (to ensure the availability of funds for future losses)


Premium Income
Investment Income
Overhead Expense
Surplus
Reserves
Reinsurance
Potential Dividends
Claims Indemnity & Expense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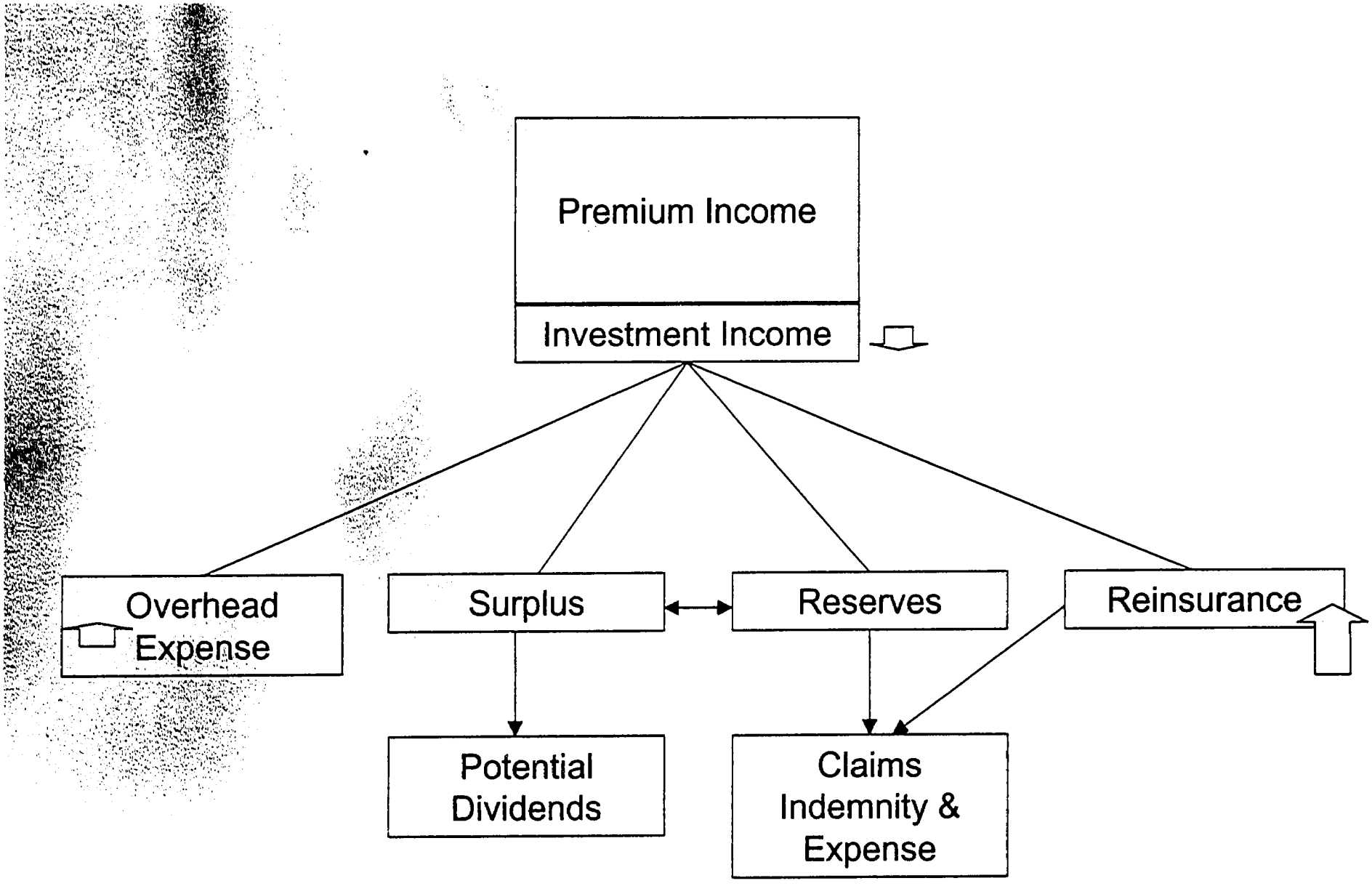
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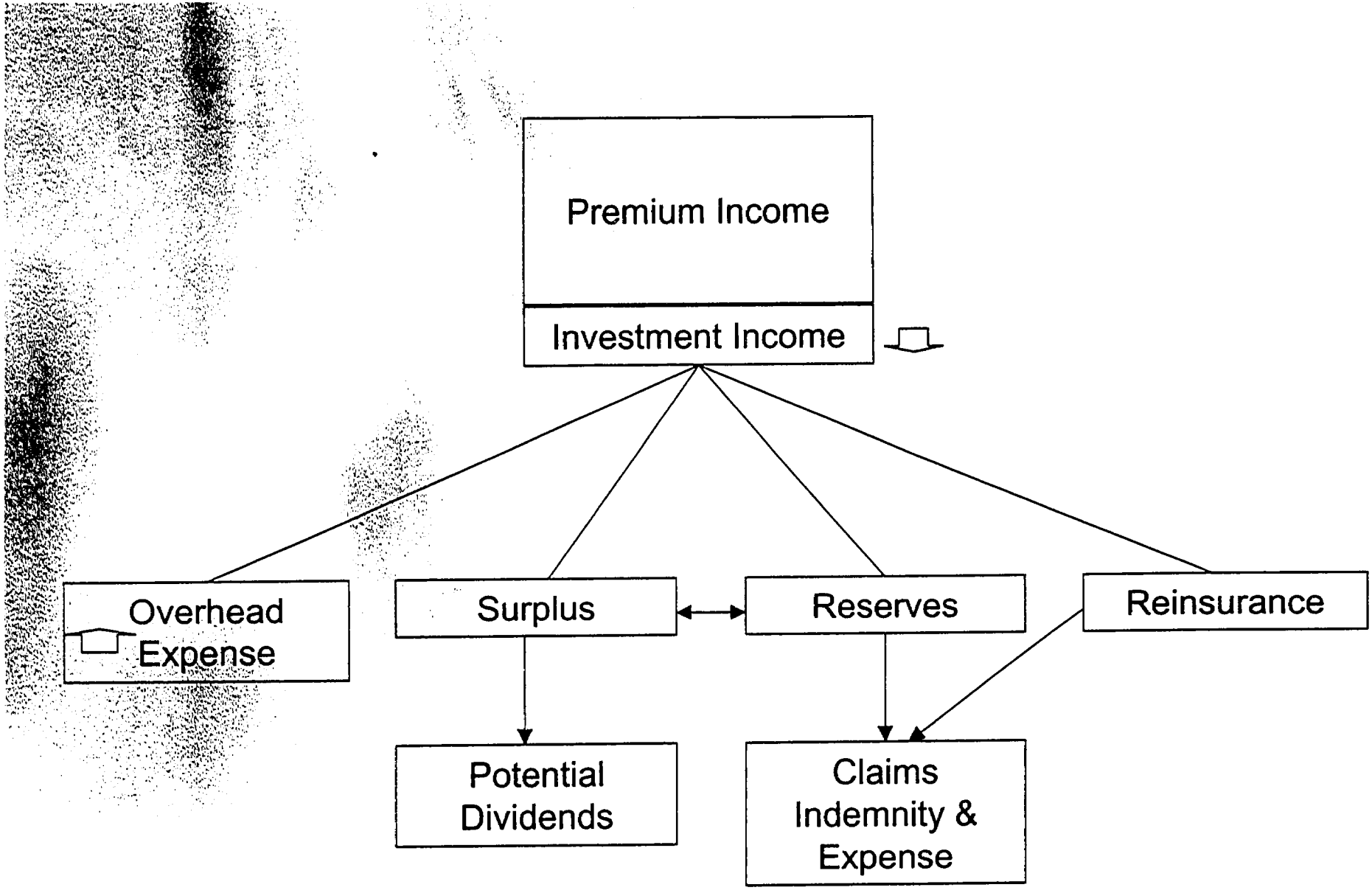
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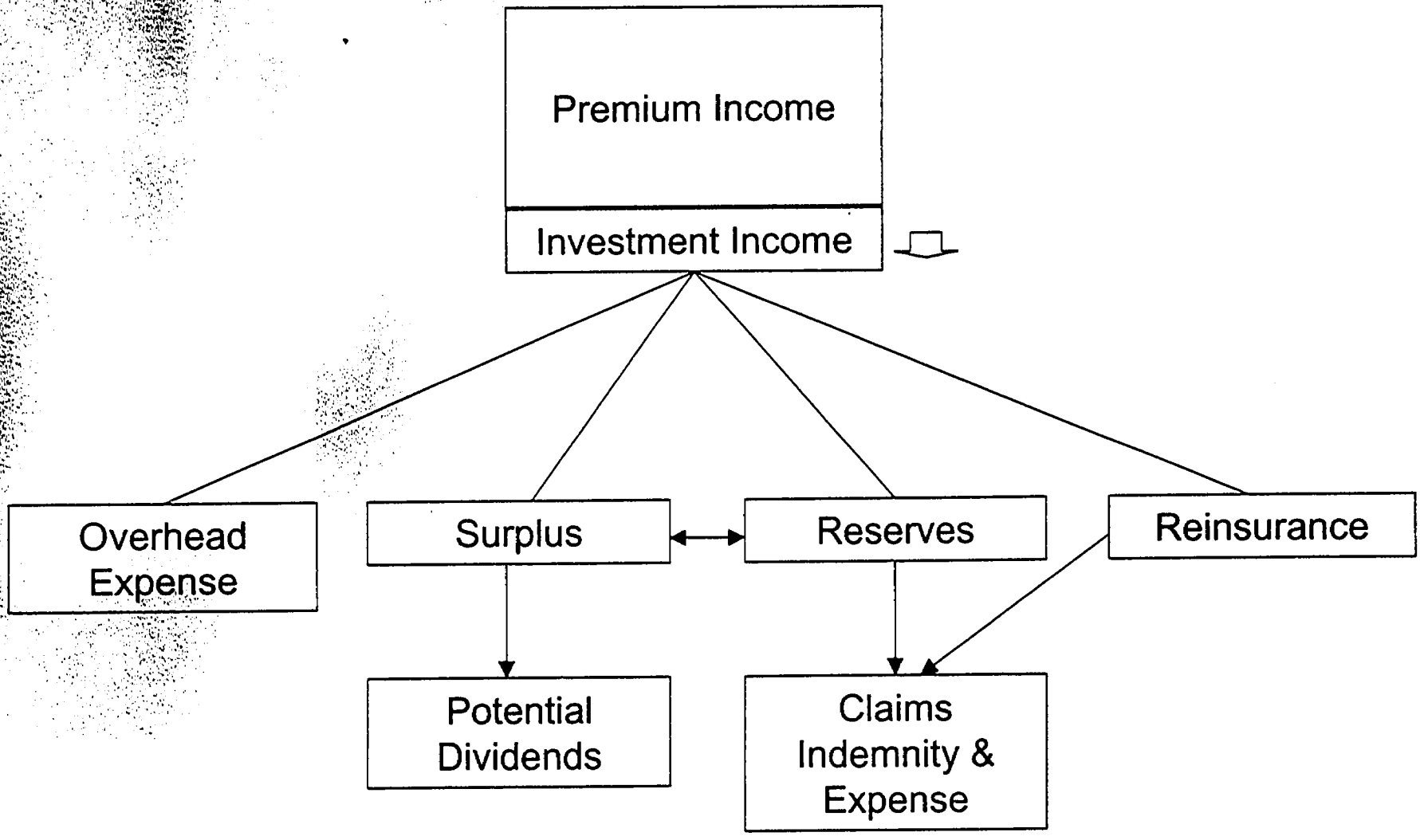
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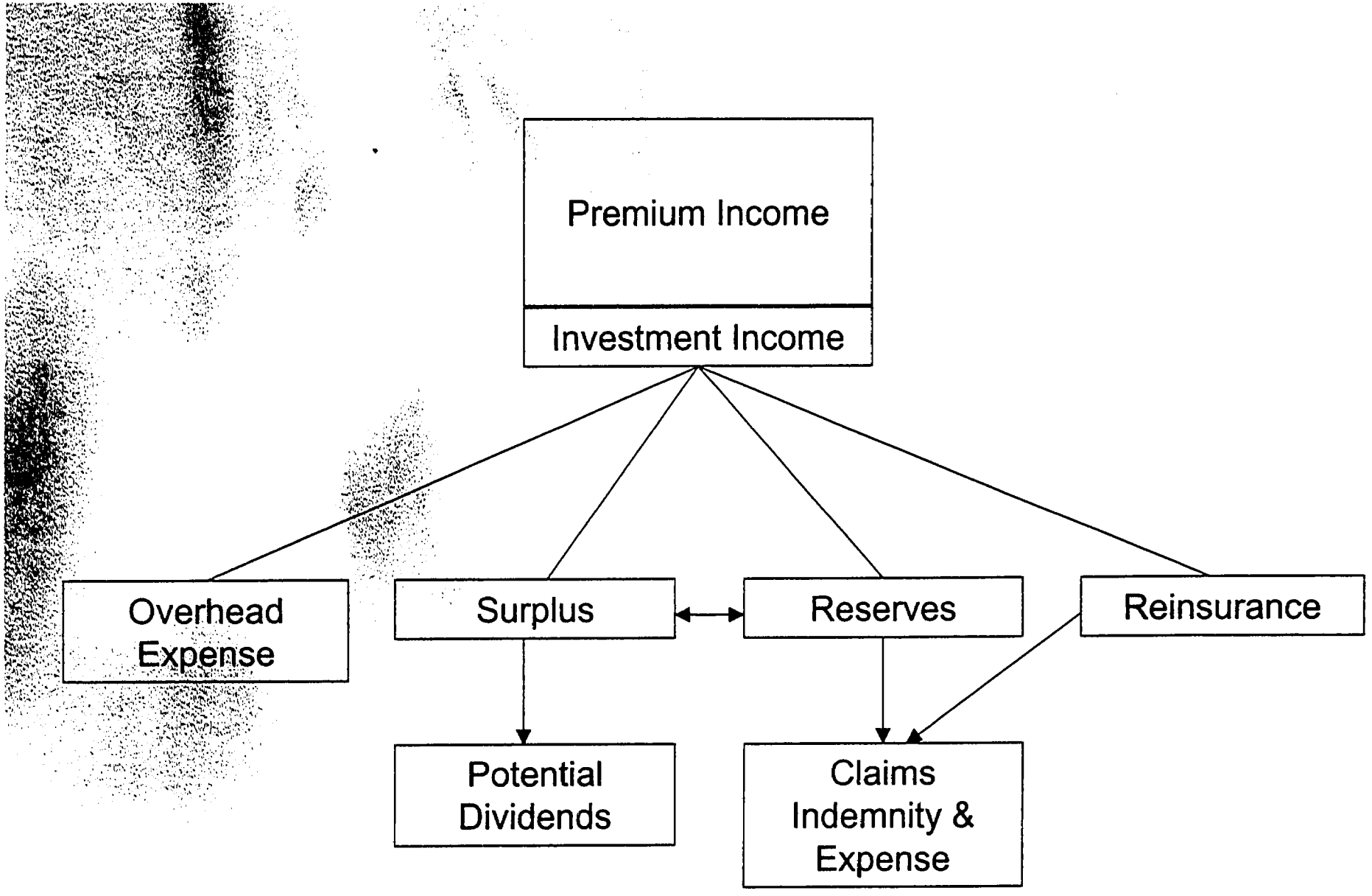
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Basic Insurance Principles

- Insurance is a product whose cost is unknown at the time it is sold
  - Forecast of losses
  - Forecast of overhead and expenses
  - Forecast of Investment Income

  And forecasts can be seriously in error if conditions change –

  The role of surplus, reinsurance and investment income

ARIZONA STATE LEGISLATURE

RURAL PHYSICIANS STUDY COMMITTEE

September 18, 2002

Ronald E. Malpiedi, Vice President and COO, MICA

Rural Physicians Study Committee
Overview of Malpractice Laws in Arizona and Other States

Tort Reform – Attempts to control the frequency and severity of claims

Damage Caps – Caps placed on economic, punitive and non-economic damages. Most caps are placed on non-economic and punitive damages.

Arizona - Article 2 Section 31 of the Arizona State Constitution prohibits laws from being enacted that limit the amount of damages to be recovered for causing death or injury of any person.

Other States – Thirty-seven states have laws that place limits on damage awards. Most of these laws apply to non-economic and punitive damages that are typically within the range of $250,000 to $1 million. Damage caps may have formulas to factor in mitigating circumstances, inflation and different types of medicine. The courts typically set the amount of damages.

States without limits on damage awards - Arizona, Arkansas, Connecticut, District of Columbia, Iowa, Kentucky, Minnesota, Mississippi, New York, South Carolina, Tennessee, Vermont, Wyoming

Periodic Payments – Allows the defendant to pay a damage award over time as opposed to one lump payment.

Arizona – Laws 1989, Chapter 289 (sections 12-582,12-583) allowed for periodic payments. The statute was ruled unconstitutional by the Arizona Supreme Court in 1994 (Smith v. Myers).

Other States – 31 states allow discretionary or mandatory periodic payments. The periodic payments may be limited by size, type of action and is usually determined by court order.

Abolition of Collateral Source Rule – Allows juries to hear evidence that claimants have been fully or partially compensated from other sources.

Arizona – Section 12-565 allows the defendant to introduce evidence of any amount or other benefit which is or will be payable as a benefit to the plaintiff as a result of the injury or death. This would include payments from sources such as disability, worker's compensation, medical insurance, etc.

Other States – 35 states have either discretionary or mandatory offset of collateral sources. There may be limitations on the type of information used such as federal benefits.

Limiting Attorney Contingency Fees – Limits the amount of an award an attorney may receive.

Arizona – Section 12-568 allows the court by request to review the reasonableness for each party's attorney fees.

Other States – 25 states have limitations on contingency fees. The limitations may up to the discretion of the court or they may be based on a sliding fee scale or by a percentage of the award.

Abolition of Joint and Several Liability – Eliminates the requirement that each party found liable is completely responsible for the damages if any other party fails to pay its portion.

Arizona – Section 12-2506 stipulates that the defendant is liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault and a separate judgment shall be entered against the defendant for that amount.

Other States – 27 states have restrictions on joint and several liabilities.

Sources Used
National Conference of State Legislatures, National Academy for State Health Policy, Westlaw

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

STATE MEDICAL LIABILITY LAWS TABLE

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Alabama	§6.5.482 (1975, 1993) 2 years from date of injury or 6 months from reasonable discovery; no suit may be brought 4 years after date of injury; minors under 4 by age 8 if statute would have otherwise expired by that time	§6.5.544 (1987) $400,000 limit on non-economic damages, including punitive damages; §6.5.547 $1 million limit on total damages (court decision upheld cap only in wrongful death actions); §6-11-21 $250,000 cap on punitive damages except for wrongful death and suits alleging patterns of intentional wrongful conduct, actual malice or defamation[2]	§6.5.545 (1987) Discretionary offset; allows the jury to be informed if medical bills and/or lost wages have been paid by a third party	§6.5.543 (1987) Mandatory periodic payment of future damages in medical injury cases in excess of $150,000		§6.5.548(1997) Expert witness must be certified in same specialty as defendant and must have practiced within previous year		Alabama Supreme Court upheld constitutionality of statute of limitations in *Barlow v. Humana*, (1986); *Tucker v. Nichols* (1983); *Reese v. Flte Memorial Hospital*, (1981); non-economic damages portion of damage awards limitations ruled unconstitutional in *Moore v. Infirmary Assoc.* (1991); cap on total damages, excluding wrongful death, overturned in *Ray v. Anesthesia Assoc.*(1995); punitive damages cap ruled unconstitutional in *Henderson v. Alabama Power Co.* (1993); non-medical malpractice statute similar to collateral source rule struck down in *American Legion Post No. 57 v. Leahey* (1996)
Alaska	§09.10.070 (1962) 2 years from discovery of injury; tolled by disability	§09.17.010 (1997) For injuries after Aug. 7, 1997, non-economic damages cap greater of $400,000 or plaintiff's life expectancy, in years, multiplied by $8,000; for severe injury, the greater of $1 million and life expectancy in years times $25,000; §9.17.020 (1997) punitive damages cap greater of $500,000 or 3 times compensatory damages, whichever is greater, unless malicious action, then greater of $7 million or 4 times compensatory damages; 50% of punitive damages to state fund	§09.55.548 (1992) Mandatory offset of collateral sources, except federal program benefits requiring subrogation and life insurance	§09.55.548 (1976) Discretionary periodic payment of future damages for medical treatment, care or custody, loss of future earnings, or loss of bodily function	§09.55.536 (1976) Mandatory submission of claims to pretrial screening panel, unless court waives this requirement or parties agree to arbitrate; results of screening admissible at later trial	§09.20.185 (1997) Expert witnesses must be licensed and trained in the defendant's discipline and certified by a board recognized by the state		Alaska Supreme Court upheld constitutionality of pretrial screening panels in *Keyes v. Humana Hospital Alaska, Inc.*, (1988)

[1] Expert witness rules commonly established by case history. Summary chart includes only rules established by statute.
[2] Underline indicates statutes overturned by decisions of court (see *Case History* for specific citation) or was repealed by act of the legislature.

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Arizona	§12.502, 542 (1971, 1984) 2 years from injury or death; foreign object or intentional fraud: 1 year from discovery; minor or unsound mind: statute begins upon removal		§12.565 (1976, 1984) Discretionary offset; evidence of collateral sources of payment for economic damages admissible at trial	§12.582 May elect for periodic payments made pursuant to court rule; claim for future damages is effective unless objecting party shows trial or arbitration should not be conducted			§12.568 (1976) Upon request by a party, the court will review the reasonableness for each party's attorney fees	Arizona Supreme Court upheld constitutionality of collateral source rule and mandatory pretrial screening panel requirement in *Eastin v. Broomfield* (1977); periodic payments statute ruled unconstitutional in *Smith v. Myers* (1994)
Arkansas	§16.114.203 (1979, 1991) 2 years from the date of injury; foreign objects: 1 year from discovery; minors: before age 9, until age 11; plaintiff must bring suit within 1 year from date of removal of disability			§16.114.208 (1979) Discretionary periodic payment of damages over $100,000; upon death of claimant, court may deduct future pain and suffering and care expenses		§16.114.207 (1979) Testimony by experts whose compensation depends upon outcome of suit prohibited		
California	Civ. Proc. §340.5 (1975) 3 years after injury or 1 year after discovery, whichever is first; in no even more than 3 years after injury, unless caused by fraud, concealment, or a foreign object; minor under age 6: 3 years or before age 8, whichever is longer; tolled for foreign body cases until reasonable discovery	Civ. §3333.2 (1975) $250,000 limit for non-economic damages	Civ. §3333.1 (1975) Discretionary offset; evidence of collateral sources may be introduced at trial	Civ. Proc. §667.7 (1975) Mandatory periodic payment of future damages award exceeding $50,000, upon request of party; payments to continue after death of plaintiff to parties to whom judgement creditor owed a duty of support			Bus. & Prof. §6146 (1975, 1987) Sliding scale fees may not exceed 40% of the $50,000, 1/3 of the next $50,000, 25% of the next $500,000, and 15% of damages exceeding $600,000	California Supreme Court upheld constitutionality of damage awards limits and collateral source rules in *Fein v. Permanente Medical Group* (1985); periodic payment of damage awards upheld in *American Bank and Trust Co. v. Community Hospital of Los Gates . Saratoga, Inc* (1984); attorney fees statute upheld in *Roa v. Lodi Medical Group, Inc* (1985); additional attorneys' fees provisions rejected by voters in 1996
Colorado	§13.80.102(5) (1988) 2 years from date of accrual; in no event more than 3 years from act; foreign objects: 2 years from discovery; minors under age 6 must bring claim before age 8	§13.21.302 (1988) $1million limit for damages against a hospital or physician; non-economic damages limited to $250,000; court may increase limit in certain situations; §13.21.203 (1989) permissible recovery for wrongful death limited to $250,000; §13.64.302.5(5) (1990) no punitive damages against a physician for adverse outcome of prescription, medically prescribed (1991) or experimental drugs (1991) where FDA protocol was followed; §13-21-102 (1990) punitive damages may not exceed actual damage award; court may increase punitive damages to 3 times in certain situations	§§13.21.111.6 (1986) Mandatory offset for sources not contracted by and paid for by the claimant	§13.64.203 (1988) Mandatory periodic payment of future damage awards exceeding $150,000	§13.22.402; §13.22.311, 401-409 (1988) Mandatory screening for claims of $50,000 or less by "arbitration panel"; findings of panel not admissible at trial; court may require mediation of medical injury claims	§13.64.401 Expert witness must be licensed physician and substantially familiar with standard of care on date of injury; §13.20.602 (1988) claimant must file certificate of review which states that an expert was consulted and is competent to testify		Colorado Supreme Court upheld constitutionality of non-economic damage awards cap in *Scholz v. Metropolitan and Pathologists*

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Connecticut	§52.584 (1969) 2 years from discovery; no more than 3 years after act; §52.555 (1991) wrongful death: 2 years from death; no more than 5 years from disputed act or omission		§52.225a (1985) Mandatory offset; court reduces award by collateral sources of payment received by plaintiff, but credits plaintiff with any premiums paid	§52.225d (1987) Discretionary periodic payment of all damages in excess of $200,000; the parties have 60 days to reach payment terms for damages over $200,000; if no agreement is reached, a lump sum is awarded	§§38a-56, 19f (1977) Voluntary pretrial screening; unanimous findings of panel members admissible at trial	§52.184c(d) (1986) Expert witness must be licensed physician practicing for 5 years before date of injury	§52.251c (1986) Sliding scale fees may not exceed: third of first $300,00; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million	
Delaware	§18.6856 (1976) 2 years from injury; 3 years from discovery if latent injury; minor: age 6 or same as adult	§18.6855 (1976) Punitive damages may be awarded only on finding of malicious intent to injure or will or wanton misconduct	§18.6862 (1976) Discretionary offset; evidence of "public collateral sources of payment" may be introduced (evidence of life insurance or private collateral sources of compensation benefits excluded)	§18.6864 (1976) Discretionary periodic payment of future damages in medical injury actions only; compensation for future pain and suffering and future expenses deducted from balance of payments on death of plaintiff	§18.6801-6814 (1976) submission to review panel on demand; negative opinion admissible as prima facie evidence at any subsequent trial; expert witness testimony may be required for panel	§18.6853-6854 (1976) Required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; experts knowledge of similar locality in order to testify	§18.6865 (1976) Sliding scale fees may not exceed: 35% of first $100,000; 25% of next $100,000; and 10% of damages exceeding $200,000	
District of Columbia	§12.301-2 (1995) 3 years from reasonable discovery; wrongful death: 1 year from death							
Florida	§95.11 (1972, 1980) 2 years from injury or discovery, no more than 4 years from injury; minors: age 8; if fraud, concealment of injury or intentional misrepresentation prevented discovery within 4 year period, 2 year limit from discovery, not to exceed 7 years after the act	§768.73 (1997) Punitive damages in excess of 3 times economic damages or $500,000 presumed excessive; §766.207, 209 (1988) where parties agree to binding arbitration, (1) net economic damages for wage loss including to 80% of wage loss and earning capacity; (2) non-economic damages limited to maximum $250,000 calculated for capacity to enjoy life; where the plaintiff refuses to arbitrate, non-economic damages may not exceed $350,000 plus net economic damages including past and future medical expenses and 805 of wage loss and loss of earning capacity; no limits where defendant refuses to arbitrate	§768.76 (1986) Mandatory offset by court, except for those collateral sources for which there are subrogation rights; §§766.207, 209 (1988) rule extends to binding arbitration cases	§768.78 (1986) Mandatory periodic payment of future damage award exceeding $250,000, at the request of a party; defendant may elect to pay lump sum for future economic losses and expenses reduced to present value; §766.207(7)(c) (1988) damages for future economic losses awarded by arbitration payable on periodic basis under 766.202(8)	§766.106-107 (1985) Court may require submission of claim to an arbitrary panel; result not admissible in a later trial	§766.102(c) (1988) Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed	Atty. Conduct Reg. 4-1.5(f)(40(b) Separate sliding scales for cases settling before filing an answer or appointing an arbitrator, cases settling before or after going to trial, and cases in which liability is admitted and only damages contested; 5 % extra for cases appealed	Voluntary binding arbitration caps found unconstitutional in *Univ. of Miami School of Medicine v. Echarte*; 1975 statute, without the subrogation exception, upheld in *Pinillos v. Cedars of Lebanon Hospital Corp.*(1981) and *Smith v. Department of Insurance* (Fla. 1987); earlier pretrial screening panel provision found unconstitutional in *Aldana v. Holub* (1980)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Georgia	§9.3.71-73, 9.63 (1992) 2 years from injury or death; in no event longer than 5 years from act or death; foreign object: 1 year from discovery; minors: age 7 and, and in no event later than age 10; agreement by parties to arbitrated tolls statute	§51.12.5.1 (1992) $250,000 cap on punitive damages, unless demonstrated intent to harm	§51.12.1 (1987) Collateral sources evidence admissible to jury		§9.9.61-63 (1997) Voluntary arbitration subject to court review; binding if prior agreement to make it so	§9.11.9.1 (1998) Complaint must generally contain an affidavit of an expert stating that the facts justify a claim of negligence		Georgia Supreme Court upheld as constitutional statute of repose in *Craven v. Lowndes County Hospital Authority* (1993); collateral source rule found unconstitutional in *Georgia Power Co. v. Falagan, et al* (1991); *Dentor v. Con-Way Southern Express, Inc* (1991)
Hawaii	§657.7.3, 671.18 (1973, 1986) 2 years from discovery, not to exceed 6 years from act; minors: age 10 or within 6 years, whichever is longer; arbitration tolls statute until 60 days after the panel's decision is delivered but for no more than 18 months	§663.8.5, 8.7 (1986) $375,000 cap for pain and suffering damages; excludes mental anguish, disfigurement, loss of enjoyment of life, and loss of consortium			§601-20 (1986) Mandatory nonbonding arbitration for all cases involving $150,000 or less; §671.11-20 (1976) mandatory submission of medical injury claim to medical claim conciliation panel; results not admissible at trail		§607.15.5 (1986) Attorney fees must be approved by the court	
Idaho	§5.219 (1971) 2 years from injury; foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later	§6.1603 (1987) $400,000 cap on non-economic damages in any tort action, unless personal injury cause by "willful or reckless misconduct" or felony; cap adjusted annually according to the state's adjustment of the average annual wage; §6.1606 (1990) removed 1992 Sunset	§6.1606 (1990) Mandatory offset of collateral sources except for federal benefits, life insurance and subrogation rights	§6.1602 (1987) Discretionary periodic payment of future damage awards exceeding $100,000, excluding cases involving intentional tort, gross negligence, or extreme deviation from standards unless agreed to by claimant	§6.1001-1011 (1976) mandatory submission of claim to hearing panel; results not admissible at trail	§6.1012 (1990); Claimant must prove negligence by direct expert testimony; §6.1013 (1976) Expert witness must have knowledge of community standards		Idaho Supreme Court upheld constitutionality of statute of limitations in *Homes v. IWASA* (1983); earlier damage awards limit applying only to medical liability overturned in *Jones v. State Board of Medicine* (1976) *cert denied* (1977)
Illinois	§735.5/13.212 (1992) 2 years from discovery but not more than 4 years from act; statute tolled for disability (where plaintiff is insane, mentally ill or imprisoned); minors: 8 years after act but not after age 22; §740.180/2 (1995) wrongful death: 2 years from death, if statute of limitation on personal injury still valid at time of death	§735.5/2.1115.1 (1997) $500,000 cap on non-economic damages; §735.5/1115 (1985) punitive damages not recoverable in medical malpractice cases	§735.5/2.1205 (1992) Claimant may apply within 30 days of judgment for 50% reduction of collateral payments for lost wages or disability benefits; 100% of medical benefits (with exceptions), but not more than 50% of total award	§735.5/2.1705-6 (1985) Voluntary or discretionary periodic payment of future damages awards over $250,000		§735.5-8 Plaintiff required to provide affidavit stating that competent expert has been consulted	§110.2.1114 (1985) Sliding scale fees may not exceed third of first $150,000; 25% of next $850,000 and 20% of damages exceeding $1 million; §735.5/2.1114 (1992) attorney may apply to the court for additional compensation under certain circumstances	Illinois Supreme Court upheld constitutionality of statute of limitations in *Anderson v. Wagner* (1979), *reversing Woodward v. Burnham City Hospital* (1987); non-economic damage award cap struck down in *Best v. Tayor Machine Works* (1997); similar 1975 statute overturned in *Wright v. Central Du Page Hospital Association* (1976); pretrial screening panel provision struck down and periodic payment of damage awards upheld in *Bernier v. Burris* (1986)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Indiana	§34-18-7-1 (1998) 2 years from act, omission, or neglect; minors: under age 6 until age 8; applies regardless of minority or other disability	§34-18-18-1 (1998) For acts prior to 1990, $100,00 cap from a single provider and $500,000 cap from all providers and Patient Compensation Fund (PCF); as of 1990, $750,000 cap for all providers and PCF; as of July 1999, $250,000 limit for each provider and a $1,250,000 for all providers and PCF; only 1 recovery per single injury; no damage caps in cases not brought against qualified providers	§34.44.1.2 (1998) Collateral sources except life insurance, insurance payments made directly to plaintiff, plaintiff's family or state/federal benefits paid before trail admissible at trail	§34.18.15.1 (1985) Discretionary periodic payment	§34.18.8.4-6 (1975) mandatory submission of claim, unless parties agree otherwise, of claims more than $15,000; panel determination is admissible at any later trail	§34.18.10.23 Medical review panel's testimony may qualify as expert testimony to establish prima facie	§16.9(5).5.1 (1975) Plaintiff's attorney fees may not exceed 15% of any award that is made from PCF (covers portion of an award that exceeds $100,000)	Indiana Supreme Court upheld constitutionality of statute of limitation, but established an exception where medical condition prevented discovery in *Martin v. Richey* 1999); original 1975 pretrial screening panel, limits on damage awards, and statute of limitation provisions upheld as constitutional in *Johnson v. St. Vincent Hospital* (1980); *St. Anthony Medical v. Smith* (1992); *Bova v. J.H. Roig, M.D* (1992)
Iowa	§614.1(9) (1997) 2 years from reasonable discovery but not more than 6 years from injury unless foreign object; minors under age 8: until age 10 or same as adults, whichever is later; mentally ill: extends to 1 year from removal of disability		§147.136 (1975) Mandatory offset of collateral sources	§668.3 (1987) Discretionary court-ordered periodic payment of future damages	§679A.1 (1981) Written arbitration agreement valid and irrevocable	§147.139 Qualifications of the expert must relate directly to problem at issue	§147.138 (1975) Court may review fees in any personal injury or wrongful death action against specified health care providers or hospitals	Eight Circuit upheld constitutionality of original 1945 statute of limitation in *Fitz v. Dolyak* (1983)
Kansas	§60.513.7(c) (1965) 2 years from act or reasonable discovery by not more than 4 years after injury; incompetent: 1 year from removal, but no more than 8 years from act	§60-19a02 (1988) $250,000 cap on non-economic damages recoverable by each party from all defendants; §60.3702 (1994) punitive damages limited to lesser of defendant's highest gross income for prior 5 years or $5 million; if profitability of misconduct exceeds cap, court may award 1.5 times profit instead; judge determines punitive damage; punitive damages unavailable in wrongful death cases	§60.3801-3807 (1992) Collateral sources admitted where plaintiff claims $150,000 or more in damages		§65.4901 (1976) Voluntary submission to medical screening panel upon request of party; §60.3501-3509 (1987) decisions admissible at any subsequent trial	§60.3412 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice		Kansas Supreme Court upheld constitutionality of statute of limitations in *Stephens v. Snyder Clinic Association* (1981); noneconomic damages cap ruled constitutional in *Samsel v. Wheeler Transport Services, Inc.* (1990); collateral source rule ruled unconstitutional in *Thompson v. KFB Insurance Company* (1993), Ks. Sup. Ct; earlier discretionary offset (1985, 1988) that applied only to medical liability actions struck down in *Farley v. Engleken (1987)*; 1965 cap on damage awards and periodic payment provision found unconstitutional in *Kansas Malpractice Victims v. Bell* (1988)
Kentucky	§413.140 (1974) 1 year from act or reasonable discovery, but not more than 5 years after act; minor and unsound mind: statute runs when disability lifted		§411.188.3 (1988) Discretionary offset of collateral sources except life insurance		§417.050 (1984) Written arbitration agreements enforceable and irrevocable			Kentucky Supreme Court ruled unconstitutional 5 year statute of limitation in *McCollum v. Sisters of Charity of Nazareth Health Corp.*(1990); collateral source rule overturned in *O'Bryan v. Hedgespeth* (1995)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Louisiana	§9.5628 (1975, 1987) 1 year from act or date of discovery, but no later than 3 years from date of injury; applies regardless of minority or disability; Civ. Code §2315.2 wrongful death: 1 year from death	$100,000 liability limit for qualified health care providers; punitive damages not recoverable, except in certain situations				§40.122.47 Medical review panel's report considered expert testimony		Appellate Court upheld the constitutionality of statute of limitation in *Valentine v. Thomas* (1983); Louisiana Supreme Court upheld the constitutionality of limits on damage awards in *Williams v. Kushner, slip. Op.* (1989), *Butler v. Flint Goodrich Hospital of Dillard University*, (1992); 1976 pretrial screening panel provision upheld in *Everett v. Goldman* (1978)
Maine	§24.2902 (1977) 3 years from cause of action; 6 years after accrual for minors or within 3 years of minority, whichever is first; foreign objects: accrue from reasonable discovery; incompetence: accrue upon lifting of disability	§18A.2.804 (1999, 1990) For wrongful death cases, non-economic damages limited to $150,000 and punitive damages limited to $75,000	§24.2906 (1990) Mandatory offset of collateral sources that have not exercised subrogation rights within 10 days after a verdict for the plaintiff	§24.2951 (1985) Mandatory periodic payments of future economic damages exceeding $250,000 at the request of a party	§24.2851-59 (1990, 1986-1989) Mandatory submission of medical injury claims to a "pre-litigation screening and mediation panel" except where all parties have agreed to bypass; any findings unanimous and unfavorable to the claimant as to both negligence and causation are admissible at any subsequent trial; for claims after January 1, 1991, panel's discovery is deemed court discovery at any subsequent trial		§24.2961 (1985-1987) Sliding scale fees may not exceed: third of first $100,000; 25% of next $200,000 and 20% of damages that exceed$200,000; for purpose of rule, future damages are to be reduced to lump-sum value	
Maryland	Cts. & Jud. Proc. §5.109 (1975) 5 years from act or 3 years from discovery, whichever is earlier; minors: statute begins at age 11; excepts reproductive system damage or foreign object injury; Cts. & Jud. Proc. §3.904 (1995) wrongful death: must be filed with 3 years of death	Cts. & Jud. Proc. §11.108 (1986, 1994) In any action for damages for personal injury accruing after October 1, 1994, $500,000 cap on non-economic damages; $620,000 cap in 2002 due to $15,000 increase every October 1 beginning in 1994; separate cap for each "direct victim"; wrongful death cases may not exceed 150% of cap		Cts. & Jud. Proc. §11.109 (1986) Discretionary periodic payment of future economic damages	Cts. & Jud. §3.2A.03-06 (1995) Discretionary submission of claims to a "health claims arbitration panel"; panel's decision on fault is "presumed to be correct" and its award is admissible as evidence at any subsequent trail; rejecting party liable to other for costs if verdict less favorable than findings	§3.2A.04 (1997) Within 90 days of filing, claimant must file certificate of expert consultation	Cts. & Jud. Proc. §3.2A.07 (1976) Court or pretrial screening panel will review disputed fees in medical injury actions	Damage award cap on non-economic damages ruled constitutional in *Murphy v. Edmonds*, 325 (1992)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Massachusetts	§§231.60D; 260.4, 7 (1986) 3 years from date of injury, but not more than 7 years from injury unless foreign object; minors: before age 6 until age 9; tolled for disability	§231,60H (1986) $500,000 cap for non-economic damages unless jury determines that there is "a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances"; if the total amount of general damages from a single occurrence for all plaintiffs exceeds $500,000, then the amount of such damages recoverable by each plaintiff will be reduced to a percentage of $500,000 proportionate to that plaintiff's share of the total amount	§231.60G (1986) Mandatory offset determined by the court		§231.608 (1975) Mandatory submission or medical injury claims to a "medical malpractice tribunal"; decision admissible at any subsequent trial; if tribunal finds against claimant, claimant must post $6,000 (or greater) bond for defendants costs if unsuccessful		§231.601 (1986) Sliding scale fees may not exceed: 40% of first $150,000, 33.33% of next $150,000, 30% of next $200,000 and 25% of damages that exceed $500,000; further limits if claimants recovery insufficient to pay medical expenses	Massachusetts Supreme Judicial Court upheld the constitutionality of pretrial screening panel requirement in *Paro v. Longwood Hospital* (1977)
Michigan	600.5838a, 5851(1846-1986) 2 years from injury or 6 months from reasonable discoverability, whichever is later, not to exceed 6 years; 6 years tolled for fraud or reproductive systems; disabled plaintiff: 1 year after injury except in cases of reproductive injury; foreign object: 6 months; minors under age 8: 6 years from date of occurrence or age 10, whichever is later (if action brought after 10th birthday, must be within the 6 year limit)	§600.1483 (1986) After April 1, 1994, $280,000 cap on noneconomic damages, $500,000 cap for non-economic damages applies to certain other circumstance; caps adjusted annually for inflation; in 2002, caps are $349,700 and $624,500, respectively	§600.6303 (1986) Mandatory offset of collateral sources, except life insurance, admissible after a verdict for plaintiff	§600.5056 (1975) third of a medical malpractice arbitration award, unless parties stipulate awards in excess of $50,000, to be paid lump sum; §600.6307 (1986) mandatory periodic payment of future economic damages excluding future medical, other health care costs and collateral source benefits; future non-economic damages reduced to gross percent cash value	§600.4902,15, 17, 21 (1987) Mandatory review by medication panel; party rejecting panel's evaluation must pay opposing party's actual cost unless verdict more favorable than panel; §600.2912g (1975) parties may enter into binding arbitration if total damages claimed are less than $75,000	§600.2912 Expert must be a licensed health professional, practice in a similar specialty, be board certified (if required on specialty), during the year preceding action had clinical or academic experience in specialty; certificate of consultation must be filed	Mich. Court Rules 8.121(b) (1981) Maximum contingency fee for a personal injury action is third of the amount recovered	
Minnesota	§541.07 (1935, 1982) 2 years from injury or termination of treatment; tolled for insanity; infant's claim must be asserted within 7 years from injury or 1 year after age of majority		§548.36 (1986) Mandatory offset of collateral sources by court if defendant brings in evidence of payments made to plaintiff	§549.25 (1988) Discretionary periodic payment of future damages in excess of $100,000		§145.682 (1989) Claimant must file an affidavit stating that an expert has been consulted		Eighth Circuit has upheld the constitutionality of the statute of limitation in *Jewson v. Mayo Clinic* (1982)
Mississippi	§15.1.36 (1976) 2 years from act or reasonable discovery, within 7 years after the act; mentally incompetent plaintiffs: 2 years after disability ceases; minors under 6: 2 years after age 6 or death, whichever is first; tolled for insanity					§11.1.61 (1990) Expert witness must be licensed physician		

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Missouri	§516.105 (1976) 2 years from act; foreign object: 2 years from discovery; in no event longer than 10 years from act or 10 years from minor's 20th birthday, whichever is later; minor under 8: until age 20	§538.210 (1986) Cap on non-economic damages adjusted annually for inflation; set at $547,000 in 2002		§538.220 (1986) Mandatory periodic payment of future damages over $100,000 at the request of party		§538.225 Affidavit of expert consultation must be filed within 90 of filing of filing action		Supreme Court of Missouri upheld constitutionality of statute of limitation in *Ross v. Kansas City Gen. Hosp. & Med. Ct.* (1980); statute of limitation from minors 12 and older ruled unconstitutional in *Strahler v. St. Luke's Hospital* (1986); limit on damage awards upheld in *Adams v. Childrens Mercy Hospital* (1991); pretrial screening panel provision overturned in *State ex rel. Cardinal Glennin Memorial Hospital v. Gaertner* (1979)
Montana	§27.2.205 (1971) 3 years from injury or discovery; in no event more than 5 years from act; tolled against a potential plaintiff where there has been a failure of disclosure of the act; minors under age 4: 3 years of age 8 or death, whichever occurs first	§25.9.411 (1995) court to impose a $250,000 limit any jury award for non-economic damages, for causes of action arising as of Oct. 1, 1995	§27.1.308 (1987) Mandatory offset of collateral sources by judge for awards greater than $50,000, in bodily injury and death cases	§25.9.4.3 (1995) Mandatory periodic payment at the request of party for awards in excess of $50,000, as of Oct. 1, 1995; in case of death, payments property of estate	§27.6.701 (1977) Mandatory review by Medical Legal Panel for actions not subject to valid arbitration agreement; panel report neither binding nor admissible at trial			Montana Supreme Court upheld the constitutionality of the pretrial screening panel statute in *Linder v. Smith* (1981)
Nebraska	§§25.222; 44.2828 (1976, 1996) 2 years from act or 1 year from reasonable discovery, but no more than 10 years after date of act; §25.213 under 21 or mentally disabled: statute runs from removal; §30.810 wrongful death: 2 years from death	§44.2825 (1976, 1986) $1 million limit on recoveries against health care providers qualifying for state-sponsored excess insurance; fundamental rule of Nebraska law prohibits punitive, vindictive, or exemplary damages	§44.2819 (1976) Non-refundable medical reimbursement insurance benefits credited against judgement, in certain actions		§44.2840-1 (1976) Mandatory review of medical injury claims except where plaintiff affirmatively waives his right to panel hearing; the panel report is admissible in any subsequent trial		§44.976 Court review for reasonableness of attorney fees in cases against health care providers	Nebraska Supreme Court upheld the constitutionality of the limit on damage awards, collateral source rule and pretrial screening panel requirement in *Prendergast v. Nelson* (1977)
Nevada	§41A.097 (2002, 1989, 1985) 3 years from injury or 2 years from reasonable discovery, whichever is first; tolled for concealment; minors: statute runs until age 10 for brain damage or birth defects; if sterility alleged, statute runs 2 years after discovery; tolled for insanity or minors ward of state	§42.005 (1996) $300,000 or 3 times compensatory damages cap on punitive damages, only awarded for fraud, oppression, or malice; §41A (2002) $350,000 cap on non-economic damages with exception for cases of gross malpractice (effective October 1, 2002); limits damages for hospitals and doctors to $50,000 when treating trauma patients	§42.020 Damages against health care providers reduced by amount of any prior payment by health care provider to the claimant; mandatory offset	§42.020 (2002, 1985) Claimant may elect to receive award for future damages in a lump sum reduced to present value, if approved by the court, or as an annuity; or by other means if the defendant posts an adequate bond or other security to ensure full payment	§41A.003-069 (2002) Abolished the mandatory submission of claims to pretrial screening panel; decision and findings were admissible at subsequent trial; unfavorable ruling made claimant responsible for defendant's court cost, if lost at trial	§41A.800 (2002) District court must dismiss cases filed without an affidavit to support allegations submitted by a medical expert who practices or has practiced in an area similar to the practice related to the alleged malpractice	§7.085 (2002, 1995) Court shall require attorneys to personally pay for the cost of expenses that result from their unreasonable conduct in civil litigation	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
New Hampshire	§507.C:4 2 year limit specific to medical malpractice found unconstitutional; §§508:4,8 (1986) 3 years from injury or reasonable discovery; infant or incompetents: 2 years from removal of disability	§507.C:7 (1977) $250,000 cap on non-economic damages; §556:13 $50,000 cap on wrongful death damages and restricted to immediate or dependent family members; after 1998, wrongful death cap raised to $150,000 and restricted to surviving spouse; §507:16 punitive damages prohibited	§507.C:7(I) (1977) Abolishes collateral source rule in medical malpractice cases	§524:6.a (1997) Periodic payment awarded at court discretion		§507.E.2 (1997) Claimants must provide expert testimony to support their claims	§508:4.e (1986) Fees for actions resulting in settlement or judgement of $200,000 or more shall be subject to court approval	New Hampshire Supreme Court struck down as unconstitutional the limit on non-economic damage awards, mandatory offset of collateral sources, and earlier provisions for discretionary award of periodic payment of future damages and attorney fees in *Carson v. Maurer* (1980); $875,000 limit on non-economic damages found unconstitutional in *Brannigan v. Usitalo* (1991)
New Jersey	§2A:14.2, 14.23 (1987) 2 years from accrual of claim or discovery; under 21 or insane: runs upon removal; wrongful death: 2 years from death, 6 months after the death is not computed as part of the time period	§2A:15.5.14(b) (1997) punitive damages cap of $350,000 or 5 times compensatory damages, whichever is greater	§2A:15.97 (1987) Mandatory offset of collateral sources, excluding workers' compensation or life insurance, admissible at trail and deductible from any verdict for plaintiff		§4:21A.1-8 (1985) Voluntary arbitration of medical claims by written agreement, if claim under $20,000	§2A.53A.27 Affidavit of consultation of expert must be filed within 60 days of filing action	Court Rules §1:2107 (1976) Sliding scale fees may not exceed third of first $500,000, 30% of second $500,000, 25% of third $500,000 and 20% of fourth $500,000; 25% cap for a minor or an incompetent plaintiff	New Jersey Supreme Court upheld the constitutionality of a 1978 pretrial screening panel statute in *Perna v. Pirozzi* (1983)
New Mexico	§41.5.13, 22 (1976) 3 years from injury; minors under 6: until age 9 to file suit; applies to all persons regardless of minority or disability; the statute is tolled upon submission to hearing panel and shall not run until 30 days after panel final decision	§41.5.6-7 (1976) $600,000 ($500,000 for acts prior to April 1995) cap to all damages, excluding punitive damages and medical care and related costs; health care providers not liable for any amount over $100,000; future medical expenses not be awarded as monetary damages		§41.5.7 (1976) Mandatory periodic payment of damages for future medical care up to $200,000, after which patient's compensation fund must pay	§41.5.14-20 (1976) Mandatory submission of medical injury claims to a hearing panel; panel report is not admissible at any subsequent trial			
New York	CVP §214.a (1975) 2 1/2 years from injury or from last treatment where there is continuous treatment for condition giving rise to claim; foreign object: 1 year from discovery; incompetence tolls statute for maximum 10 years		Civ. Prac. §4545 (1981) Mandatory offset of collateral sources made by the court	Civ. Prac. §5031-5039 (1985) Mandatory periodic payment of future damages in excess of $250,000; parties may agree to lump sum payment; pain and suffering damages paid within a period no longer than 10 years	CPLR §3045 (1991) Defendant may concede liability if plaintiff agrees to arbitrate; if plaintiff refuses, defendant's concession of liability cannot be used for any other purpose; Public Health §4406.2 HMOs can put arbitration clauses in contracts, but not as a condition of joining	§3012.A Certificate of consultation of expert must be filed within 90 days of filing complaint	Jud. §474a (1985) Sliding scale fees may not exceed 30% of first $250,000, 25% of second $250,000, 20% of next $500,000, 15% of next $250,000 and 10% over $1.25 million	New York's highest court upheld the constitutionality of a pretrial screening panel statute in *Treyball v. Clark* (1985)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
North Carolina	§1.15 (1979) 3 years from act or 1 year from reasonable discovery, but not more than 4 years after injury; foreign object: 1 year from discovery, but not more than 10 years from last act; wrongful death: 2 years from death	§1D.25 (1995) Punitive damages cap of $250,000 or 3 times compensatory damages, whichever is greater			§7A.38.1 (1997) Mandatory mediation	§90.21.12 (1990) Expert must testify to community standard of care; §8C.1 Rule 702 expert must be licensed		North Carolina Court of Appeals upheld the constitutionality of the statute of limitations in *Roberts v. Durham County Hospital Corp.* (N.C. App. 1982)
North Dakota	§§28.01.18, 25 (1975) 2 years from act or reasonable discovery, but not more than 6 years after act, unless concealed by fraudulent conduct of defendant; disability, except minority, tolls statute for 5 years, in no case after 1 year from removal of disability or 6 years total; minors: 12 years	§32.42.02 (1995) $500,000 cap on non-economic damages; §32.03.2.08 economic damage awards in excess of $250,000 subject to court review for reasonableness	§32.03.2.06 (1987) Discretionary offset of collateral sources, excluding life insurance, death or retirement benefits or any insurance purchased by recovering party	§32.03.2.09 (1987) Discretionary periodic payment of future economic damages for continuing institutional or custodial care for a period of more than two years; adequacy of payments subject to continuing court review	§32.42.03 (1996) Attorneys must disclose alternative dispute resolutions option; good faith effort to resolve dispute required	§28.01.46 A claimant is required to obtain supportive expert opinion within 3 months of filing complaint		A $300,000 limit on medical liability awards and an earlier discretionary offset in cases involving $100,000 or more were struck down as unconstitutional in *Arneson v. Olson* (N.D. 1978)
Ohio	§2305.11 B(1) (1990) 1 year after reasonable discovery; if plaintiff gives written notice before the 1 year expires, suit may be brought within 180 days of the notice; persons with legal disability must bring suit within 4 years after occurrence; for actions accruing as of Jan. 27, 1997, 6 year statute of repose; minor, unsound mind, or imprisoned: tolled until disability removed; wrongful death: 2 years from death	§2323.54 (1997) as of Jan. 27, 1997, non-economic cap of $250,000 or 3 times economic damages up to $500,000, whichever is greater; for more serious loss, $1 million or $35,000 times remaining life expectancy; §2315.21 (1997) punitive damages cap or $100,000 or 3 times compensatory damages, except for defendants that employ more than 25 persons, for whom cap is $250,000 or 3 times compensatory damages; prohibits punitive damages if defendant already paid amount of cap of punitive damages in another case	§23 (1975) Evidence of collateral sources in medical actions, except for insurance benefits paid for by plaintiff or employer (but including workers' compensation), admissible at trail	§2323.57 (1987) Mandatory periodic payment of future damages over $200,000 at request of party	§2711.21 (1975, 1987) Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties; decision is not admissible at any subsequent trial; prior to 1987 amendment, submission was mandatory and results were admissible	§2743.43 (1975) Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching; §2305.01.1 claimant must file certificate of consultation with expert		Ohio Supreme Court ruled unconstitutional a comprehensive tort reform package passed in 1997 that included noneconomic damage caps in *Ohio Academy of Trial Lawyers v. Sheward* (1999); a $200,000 limit on general damages struck down in *Morris v. Savoy* (1991); a $250,000 limit on non-economic damages overturned in *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the 8th District twice upheld the collateral source rule in *Morris, et al. v. Savoy* (1991) and *Charles William May v. Tandy Corp., et al* (1993) and *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the Court of Appeals of Ohio (11th District) struck down collateral source rule in *Schenk v. The Cleveland Electric Illuminating Company* (1994); Ohio Supreme Court upheld the 1975 pretrial screening panel statute in *Beatty v. Akron City Hospital* (1981)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Oklahoma	§§76.18 (1987) 2 years from reasonable discovery; after 3 years from act, recovery limited to past and future actual medical and surgical expenses; §12.96 (1988) minors under 12: 7 years; minors over 12: 1 year after attaining majority but in no event less than 2 years from injury; incompetents: 7 years from injury unless adjudged incompetent, then 1 year after such adjudication, but in no event less than 2 years from injury	§23.9.1 (1998) $100,000 cap on punitive damages for reckless disregard; punitive damages cap of $500,000, 2 times compensatory damages, or benefit derived by defendant from his conduct for intentional and malicious acts (waived in certain circumstances); discretionary waiver of damages by court if defendant already paid punitive damages for same action	Discretionary offset of collateral sources				§5.7 (1953) Maximum percentage: fee may not exceed 50% of net judgement	Oklahoma Supreme Court upheld 2.year statute of limitations as constitutional in *McCarroll v. Doctors General Hospital* (1983); 3 year statute of repose on all damages other than past and future medical and surgical expenses ruled unconstitutional in *Wofford v. Davis* (Okla. 1988); earlier limit on damage awards struck down in *Reynolds v. Porter* (1988)
Oregon	§§12.110;160 (1988) 2 years from reasonable discovery; but not more than 5 years from act; fraud: 2 years from reasonable discovery; minors or insane: 5 years from accrual or 1 year after disability ceases; wrongful death: 3 years from death or reasonable discovery	§18.540, 560 (1987) $500,000 cap on non-economic damages (overturned except with regard to wrongful death); §18.550 (1989) no punitive damages awarded against licensed physician unless malice is shown; 60% of punitive damages paid to Criminal Injuries Compensation Account	§18.580 (1987) Discretionary offset after judgement of collateral sources by court, except benefits plaintiff must repay, life insurance, retirement, disability, pension plans or social security				§18.540 Attorneys fees from punitive damages may not exceed half the claimant's 40%	Oregon Supreme Court ruled non-economic damages cap unconstitutional, except in wrongful death suits, in *Lakin v. Senco Products, Inc* (1999)
Pennsylvania	§42.5524 (1975) 2 years from injury or reasonable discovery; §42.5533 minor: 2 years after age of majority	§40.1301.812.A(g) (1997) Effective Jan. 25, 1997, punitive damages cap of $100,000 or 2 times compensatory damages; members of Medical Professional Liability Catastrophe Loss Fund, in effect, subject to limited liability			§40.1301.825A (1975) Mandatory "conciliation hearing", which may be a settlement conference or mediation as the parties prefer	§1301.821.A Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position		Pennsylvania Supreme Court found a statute providing for a mandatory offset of collateral sources in medical liability actions unconstitutional by the in *Mattes v. Thompson* (1980); earlier mandatory pretrial screening panel struck down in *Mattes v. Thompson* (1980); panels may exist as long as participation is voluntary and the outcome is not binding; attorney fee limits struck down in *Heller v. Frankston* (1984)
Rhode Island	§§9.1.14.1; 10.7.2 (1976, 1988) 3 years from injury, death or reasonable discovery; minors and incompetents: 3 years from removal of disability	§9.1.8 (1997) Punitive damages not recoverable against executor or administrator of an estate; §9.19.41 (1997) $100,000 minimum recovery in any wrongful death action	§9.19.34.1 (1986) Mandatory offset by court in medical liability actions, if evidence is admitted	§9.21.12-13 (1986) Mandatory conference on periodic payment where judgment exceeds $150,000		§9.19.41 (1997) expert must have training/ education to qualify as an expert		Pretrial screening panels were found unconstitutional in *Boucher v. Sayeed* (1983)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
South Carolina	§15.35.45, 15.3.40 (1977-1988) 3 years from injury or reasonable discovery, but not more than 6 years after act; foreign object: 2 years from discovery; minors: tolled, but no more than 7 years from act or 1 year from majority; tolled for disability, up to 5 years or 1 year after disability ceases							
South Dakota	§15.2.14.1, 221 (1984) 2 years from injury; tolled for fraud or foreign object until end of treatment; tolled for minority for 3 years or until age 8 if under age 6; metal illness: tolls statute up to 5 years; 1 year from removal; wrongful death: 3 years from death	§21.3.11 (1997, 1985) $500,000 cap on non-economic damages	§21.3.12 (1977) Discretionary offset in medical liability cases, except benefits that have a right if subrogation or were paid for by plaintiff	§21.3A.1-12 (1986-1988) Mandatory periodic payment of future damages in excess of $200,000 or past and future damages of $500,000, whichever is less; discretionary at the request of a party	§21.25B.1 (1976) Parties may agree to arbitrate for past and future services; revocable as to future services			The South Dakota Supreme Court rejected the discovery rule in *Alberts v. Giebink* (1980); law reducing statute of limitation for minors ruled unconstitutional in *Lyons v. Lederle Laboratories* (1989); $1 million cap on total damages ruled unconstitutional, reviving prior $500,000 cap on noneconomic damages, in *Knowles v. U.S.* (1996)
Tennessee	§29.26.116 (1975) 1 year from discovery, but no more than 3 years from act unless foreign object; foreign object: 1 year from discovery; under 18 or unsound mind: 1 year from removal		§29.26.119 (1975) Mandatory offset except for assets purchased by plaintiff or private insurance		§29.5.101 All causes of action may be submitted to the decision of arbitrators except wher 1 of the parties is an infant or a person of unsound mind	§29.26.115(b) (1975) Expert witness must be licensed in Tennessee or contiguous state and practice for one year preceding date of injury	§29.26.120 (1975) Plaintiff's attorney fees in a medical injury suit shall not exceed third of all damages awarded	Tennessee Supreme Court upheld the constitutionality of statute of limitation in *Harrison v. Schrader* (1982)
Texas	Civ. §4590i.10.01 (1977) 2 years from occurrence (discovery); minors under 12: until age 14; otherwise applies to all regardless of minority or disability	Civ. §4509.11.02-04 (1977) approximately $1.3 million cap on wrongful death damages, adjusted annually for inflation Civ. Prac. & Rem. §41.008 (1995) punitive damages cap as of Sept. 1, 1995 of 2 times economic damages, plus non-economic damages (not to exceed $750,000), or $200,000, whichever is greater, with certain exclusions				§14.01 Expert must have experience relating to complaint; Tex. Rev. Civ. Stat. Ann. 4590I, §13.01 plaintiff must post file on expert w/in 90 days of filing		The Texas Supreme Court struck down limit on damage awards as unconstitutional in *Lucas v. United States* (1988); limit subsequently found constitutional only in wrongful death cases in *Rose v. Doctors Hosp.* (1990)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Utah	§78.14.14 (1985) 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	§78.14.7.1 (1986) $250,000 cap on non-economic damages	§78.14.4.5 (1985) Mandatory offset by court except for benefits where subrogation rights exist	§78.14.9(5) (1986) Mandatory periodic payment of future damages that exceed $100,000, exclusive of attorneys' fees and costs	§78.14.8-16 (1985) Decision of pre-litigation panel may be considered binding arbitration upon written agreement of parties; mandatory submission of claims to panel; panel recommendations not admissible at subsequent trial		§78.14.7(5) (1985) Contingency fee shall not exceed third of award	Utah Supreme Court ruled unconstitutional the minority provision of the statute of limitation in *Lee v. Dr. Lynn Craufin*; *Griffith v. Dr. J. Dallas Van Wagoner* (1993); this reversed an earlier decision in *Allen v. International Health Care, Inc.* (1981)
Vermont	§12.521, 551 (1977) 3 years from injury or 2 years from reasonable discovery, but no more than 7 years from act, excluding concealment and foreign objects; foreign object: 2 years from discovery; tolled until removal of disability				§12.7002 (1995) Mandatory submission to pretrial arbitration panel; findings subject to appeal unless parties agree to binding arbitration			
Virginia	§8.01.229, 243 (1959, 1987) 2 years from injury, but not more than 10 years from act; foreign object or fraud: 1 year from reasonable discovery; infants: 5 years from date of accrual of cause of action; for claims accruing on or after July 1, 1987, minors under 8: age 10; age 8 or older: 2 years after last treatment unless; minors who were 10 or older on or before July 1, 1987: 2 years from that date to bring an action	§8.01.581.15 (1976-1983) $1.5 million cap on recovery damages for bodily injury or death, shall increase on July 1, 2000 by $50,000 and every July 1 after that until 2007 and 2008 when the final increases will be $75,000 per year; cap applies for each injury, regardless of number of theories or defendants; §8.01.38.1 (1992) $350,000 cap on punitive damages		§8.01.424 Periodic payment of awards permitted, if reviewed by court and secured by bond or insurance	§8.01.581.2, 8 (1997) Review by pretrial panel by request; findings non-binding; testimony of panel members, except chair, admissible; §8.01.581.12 (1997) parties permitted to agree in advance of treatment to binding arbitration, with period of patient withdraw	§8.01.581.20 (1992) Claims must be supported by expert testimony; physicians must have had an active clinical practice in the field about which he will testify within year of incident		Virginia Supreme Court upheld constitutionality of a prior $750,000 cap on damage awards in *Etheridge v. Medical Center Hospitals* (1989); pretrial screening panel statute upheld as constitutionality in *Speet v. Bauaj* (1989)
Washington	§4.16.350 (1971, 1988) 3 years from injury or 1 year from discovery, whichever is later, but no more than 8 years after act; fraud, concealment or minority toll statute; foreign object: 1 year from discovery; wrongful death: 3 years from death	§4.56.250 (1986) Noneconomic damages in person injury suit may not exceed an amount determined by multiplying 0.43 by the average annual wage in state and by the life expectancy of the person incurring noneconomic damages; a plaintiff's life expectancy shall not be less than 15 years for the purpose of determining maximum noneconomic damages	§7.70.080 (1976) Information on collateral sources may be introduced except for insurance purchased by plaintiff or employer	§4.56.260 (1986) Mandatory periodic payments in personal injury actions of future economic damages of $100,000 or more			§7.70.070 (1976) In any medical injury the court shall determine the reasonableness of each party's attorney fees	Washington Appellate Court upheld constitutionality of statute of limitation on constitutional in *Duffy v. King Chiro. Practice Clinic* (1977); limit on damage awards struck down in *Sofie v. Fibreboard Corporation* (1989)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
West Virginia	§55.7B.4 (1986) 2 years from injury or reasonable discovery, whichever occurs last; in no event longer than 10 years after injury; minors under 10: 2 years from injury or by age 12, whichever provides a longer period; statute tolled for any period during which fraud or concealment prevents discovery	§55.78.9 (1986) $1 million cap on non-economic damages; court must instruct jury				§55.75.7 (1986) Expert witness must be licensed physician and engaged in the same or substantially similar medical field as defendant		West Virginia Supreme Court upheld constitutionality of limit on damage awards in *Robinson v. Chaleston Area Medical Center* (1991)
Wisconsin	§893.55, 56 (1979) 3 years from injury or 1 year from discovery, but not more than 5 years from act; foreign object: 1 year from discovery or 3 years from act, whichever is later; minors: by age 10 or standard provision, whichever is later	§893.55(4)(d) (1995) For acts as of May 25, 1995, $350,000 cap adjusted annually for inflation for non-economic damages, excluding wrongful death cases, which are limited to $500,000 for a child and $350,000 for an adult	§893.55(7) Effective May 25, 1995, collateral source information is admissible at trial	§655.015 (1986, 1995) For settlement or judgement for act occurring on or after May 25, 1995 in excess of $100,000, award paid into interest baring fund, from which periodic payments are made	§655.42, 442-5 (1985, 1989) Voluntary submission of medical injury claims to mediation panel; findings of panel inadmissible at subsequent court action		§655.013 (1986) Sliding scale may not exceed: third of first $1 million or 25% or first $1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding $1 million	The Wisconsin Supreme Court upheld the constitutionality of earlier statute of limitation in *Rod v. Farrell* (1980); earlier cap on non-economic damages ruled unconstitutional in *Jelenik v. The Saint Paul Fire and Casualty Insurance Company* (1994); periodic payment awards upheld in *State ex re. Strykowski v. Wilkie* (1978)
Wyoming	§1.3.107, 1.38.102 (1977) 2 years from injury or reasonable discovery; minors: until age 8 or within 2 years, whichever is later; legal disability:1 year from removal; wrongful death: 2 years from death	Limits on damage awards prohibited by state constitution					Ct. Rules, Contingent Fee R. 5 (1997) Where recover is $1 million or less: third if claim settled prior 60 days after filing, or 40% if settled after 60 days or judgement; 30% over $1 million	Wyoming Supreme Court struck down the 1986 pretrial screening panel statute requiring mandatory submission of all medical injury claims to a "medical review panel" in *Hoem v. Wyoming* (1988)

Sources: National Conference of State Legislatures (September 2002)
McCullough, Campbell and Lane, *Summary of United State Medical Malpractice Law*, available on the Web at http://www.mcandl.com/states.html
American Tort Reform Association (ATRA)

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Keeping the Doctor Away

What Makes Arizona Unattractive to Physicians

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Executiv Summary

Arizona has a shortage of physicians, a situation that will worsen unless the government policies and regulations that caused the shortage are revised or rescinded.

There is plenty of anecdotal evidence of a shortage. Patients complain about crowded emergency rooms and doctor offices, about the difficulty of making an appointment with a general practitioner or specialist, and about feeling like a widget on an assembly line once inside a hospital or doctor's office.

Doctors complain about long hours for less pay, about onerous paperwork and regulations, and about experienced peers retiring at a relatively young age from a profession they love—or would love if they were allowed to practice medicine without bureaucrats and lawyers coming between them and their patients.

The anecdotes are based in fact. The state's ratio of physicians to population is lower than recommended ratios and lower than most other states, although Arizona has a climate and lifestyle that should be attractive to physicians. The ratio is lower in Arizona because of factors that are outside the control of patients, physicians, insurance companies and even the state government. Although the same factors can be found to some degree in every state in the nation, few states can match Arizona in the way that the factors have come together to produce a shortage.

All patients in all states are suffering from misguided federal policies that stopped a free market in health insurance from developing 60 years ago. Unlike the other necessities of life like food, shelter and clothing, there is not a consumer-led, bottom-up free market in health insurance in America, in which the consumer is king and in which the consumer has a wide variety of service and price options.

All physicians in all states are being treated to some extent like indentured servants, having to provide many services below cost, having to provide uncompensated care for the uninsured and having to work in emergency rooms without recompense because of federal regulations.

But in Arizona these factors are exacerbated by the state's high percentage of uninsured patients, which is primarily the result of the state's high percentage of poor immigrants and non-citizens–which in turn is the result of federal immigration policy and the state's proximity to Mexico. In a very real sense, federal policy has put a hidden tax on physicians. This in turn results in fewer physicians being attracted to the state.

The authors of this report are very pro-immigration, believing that the long-term benefits of immigration far outweigh the short-term costs. However, the inescapable fact is that physicians and other health care providers are bearing a disproportionate share of the costs. The dilemma is this: There is little incentive for physicians to move to the state and treat the uninsured, and, given the lack of a true free market in health insurance, there are no options for poor immigrants other than to receive uncompensated care.

The dilemma cannot be solved by continuing the failed government policies of the last 60 years. It can only be solved by making health insurance more affordable and available for citizens and non-citizens alike, through free market reforms. This report specifies how that can be done and provides statistics to back up its findings and conclusions.

Such insurance reforms must go hand-in-hand with immigration reform. Although it is beyond the scope of this report to describe in detail what those reforms might be, it is clear that steps must be taken to address the underground immigrant economy and its impact on the health care delivery system in Arizona. At the minimum, consideration should be given to reforms that enhance the movement of immigrants out of the hidden economy and into the mainstream. In fact, our findings suggest that reform of immigration policy is a critical component of any comprehensive reform of the health care system.

Introduction

Anecdotal experiences of Arizona doctors and patients over the past several months have led many health care providers to the unproved perception of an incipient physician shortage in the state. One of this study's co-authors is a physician in active clinical practice, and has first hand knowledge of many of these anecdotes.

Patients complain of ever-increasing difficulty obtaining prompt appointments with primary care physicians or specialists, often waiting for periods of weeks for initial appointments. Many complain that, upon finally getting in to see the doctor, they are principally seen by physician-assistants or nurse practitioners, rather than by the doctor they had hoped to see.

The waiting rooms of doctors in specialties not known for handling high volumes of patients are oftentimes packed to "standing room only" capacity.

Both doctors and patients are frustrated by the ever-increasing need to navigate complex menus when attempting to phone health care provider offices. These systems are brought online in order to deal with the great increase in phone calls inundating provider offices.

Appointments for tests or procedures have become more difficult as well, sometimes requiring several weeks before the test or procedure can be performed. These waiting times are not the result of health insurance pre-authorization requirements. Rather, they are due to the crowded schedules of the health care providers. The physician co-author of this report has personally intervened in attempts to facilitate appointments for his patients with consultants or for tests, only to find that the desired appointment times are legitimately "booked up."

Patients have reported seeking the services of hospital emergency rooms in hopes of "moving ahead of the queue" to receive tests and/or non-urgent medical attention. This has contributed to emergency room overcrowding, stressing Emergency Department staffs, and longer waiting times for emergency room care.[1] Doctors privately admit informing their patients, on occasion, that they might get needed tests more expeditiously if they present to an emergency room.

Physicians notice their colleagues retiring at earlier ages than originally planned. Many are selling their practices to hospitals and becoming employees of the practice, significantly shortening their work hours, and thus availability to patients. Doctors who had originally planned to work until they reached their 70s,

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[1] See for instance, "A Tragedy Waiting to Happen? Several Factors Blamed For Acute ER Overcrowding in Valley Hospitals," Paul Matthews and Kerry Fehr-Snyder, *Arizona Republic*. January 13, 2001.

now intend to retire in their 50s. This changing attitude towards earlier retirement is augmented by reports in professional newsletters suggesting this phenomenon is nationwide.[2]

Many physicians report difficulties in recruiting doctors from other states, or who have recently graduated residency programs, to join their busy practices. Some have tried for more than 1½ years to sign on a new associate.

Articles abound in the peer reviewed medical literature highlighting a generalized malaise among health care providers as the patient-doctor relationship continues to undergo change.[3] There is also the widespread perception among physicians that the quality of applicants to specialty residency programs is deteriorating.[4] These factors further impact physician morale and perceptions.

Despite the fact that surveys in the peer reviewed medical literature do not point to an impending national physician shortage, the day-to-day experiences of patients and doctors in this region of the country have led many doctors to conclude intuitively that a shortage exists in Arizona.[5]

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[2] The American College of Surgeons has long boasted that its active dues paying Fellows have a stable average retirement age of slightly over 62, exemplifying the tendency of surgical specialists to work until their later years. However, in February of this year, they reported that for the first time, the average retirement age has dropped significantly:

Year	# retirements	Average Retirement Age
1992	325	62.2
1993	396	62.1
1994	443	62.3
1995	522	62.6
1996	670	62.5
1997	705	62.7
1998	681	63.3
1999	931	63.2
2000	689	59.9

(Based on the age of Active Dues Paying Fellows at the time they report their retirement. Age for dues exempt status changed from 70 to 65 in 1999.) Source: American College of Surgeons, Chicago, Illinois.

[3] See, for instance, "Why Are Doctors So Unhappy?" Editorial, *British Medical Journal*, Volume 322, page 1078, May 5, 2001.

[4] "Is the Quality of Surgical Residency Applicants Deteriorating?" J.B. Cofer et al, *The American Journal of Surgery*, Volume 181 (2001), pages 44-49. "Medicare and Graduate Medical Education," John K. Iglehart, *New England Journal of Medicine*, February 5, 1998, Volume 338, Number 6, pages 401-407. "Graduate Medical Education, 1997-1998," Marvin R. Dunn et al, *JAMA*, September 2, 1998, Volume 280, Number 9, pages 809-812.

[5] "The Projected Supply of Physicians, 1998 to 2020," Phillip R. Kletke, Ph.D., *Physician Characteristics and Distribution in the US, 2000 Edition*, pages 361-375, American Medical Association, Chicago, Illinois. "Patterns of Graduating Medical Student Career Selections From

The goal of this study was to find out if there is empirical evidence to back up the anecdotal suggestion of an Arizona physician shortage, and to uncover possible causes of the shortage, if a shortage is found.

Physician-Patient Ratios

Free market economists are reluctant to enter into a discussion on the proper ratio of physicians to patients. Any attempt to predict or plan a "proper' allocation of goods or services in a given marketplace would amount to an exercise of what Nobel laureate Friedrich A. Hayek has called the "fatal conceit." The price system, operating under the law of supply and demand, ultimately leads to the proper allocation of resources. Central planning cannot work efficiently in a social context.

The market is the spontaneous interaction of the needs, values, and aspirations of millions of individuals, each with his own individual context, each context changing from moment to moment. Using the price system as the principle means of transmitting information, and subject to the law of supply and demand, millions of transactions and interactions take place simultaneously, each serving the perceived best interests of the actor at the margin. The more populous and diverse a society, the more difficult is prediction and planning.

Nevertheless, regulatory processes, including systems of price controls, have been imposed on the health care industry for decades, thus precluding the development of an unfettered health care marketplace. In effect, health care has been subject to central planning for much of the latter part of the Twentieth Century. With no true market apparatus existing for the distribution of goods and services, health care policy planners have had no alternative but to determine optimal ratios to target the distribution of physicians (service providers) to patients (consumers) in society.

The Bureau of Health Professionals and the Graduate Medical Education National Advisory Committee have adopted criteria upon which they have based the development of physician-patient ratios. These ratios have been used to serve health policy planners for the last two decades. The Bureau of Health Professionals recommends a distribution of 230.9 physicians per 100,000 population; the Graduate Medical Education National Advisory Committee recommends 194.6 physicians per 100,000 population.[6]

1993 to 1998 and Their Effect on Surgery as a Career Choice," Yale D. Podnos, et al, *Archives of Surgery*, Volume 134, August 1999, pages 876-881.

[6] The Bureau of Health Professionals recommended physician/population ratios, as well as those recommended by the Graduate Medical Education National Advisory Council, are cited and used as guidelines in *Surveys of Arizona Physicians, 1992-1993*, *Surveys of Arizona Physicians 1992-1999*, and *State of the State: Graduate Medical Education in Arizona, January 2000*, all prepared by the Arizona Council for Graduate Medical Education, Phoenix, Arizona. All records for the Council have

In 1992, the Arizona Council for Graduate Medical Education, with data on the number of in-state physicians provided by the Arizona Board of Medical Examiners, used the average of the two above-referenced ratios to determine that the physician-patient ratio was satisfactory at that time. It projected an adequate supply of physicians in Arizona in the year 2000, using consistent criteria and population projections for the state.[7]

Utilizing this same approach, we compared the number of in-state Arizona physicians provided by the Arizona Board of Medical Examiners to the actual Arizona population as provided by the US Bureau of the Census for the year 2000.[8] The results point to a shortage.

Table 1. Physician-Patient Ratios in Arizona

	1990*	2000**
Arizona Population (millions)	3.7	5.1
In-State Arizona Physicians	7,306	9,474
Physician/Patient per 100,000	198	185

Source: * Data from the Arizona Council on Graduate Medical Education
** Data from Arizona Board of Medical Examiners and US Bureau of the Census

Since the "number of in-state physicians" is not a true reflection of the actual number of physicians providing direct patient care, we then adjusted the data for the year 2000 by subtracting from the total in-state physician population the number of physicians who report themselves to be in Administrative positions rather than clinical medicine, and the number of physicians who maintain their licenses to practice, but report themselves retired from medical practice. This information was available from the Arizona Board of Medical Examiners for the years 1996 to 2000, but was not available for earlier years (and was not included in

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been transferred to the Phoenix Area Medical Education Consortium. For information call or write: 4001 N. 3rd Street, Suite 405, Phoenix, AZ 85012, (602) 631-6551. The 2000 report, titled "State of the State: Graduate Medical Education in Arizona," says this about the Flinn Foundation and the Council: "AzCGME has been funded for ten years by the Flinn Foundation as part of the Foundation's continuing interest and commitment to medical education...As of January 2000, the Council will cease to exist."

[7] *Surveys of Arizona Physicians 1992-1999*, Arizona Council for Graduate Medical Education, Phoenix, Arizona. This series of reports updated the original predictions made in a 1989 report prepared by the Flinn Foundation Commission on Medical Manpower, entitled "Arizona Physicians Today and Tomorrow." A final report was released by the AzCGME in 2000 entitled *State of the State: Graduate Medical Education in Arizona, January 2000*. That report said that the prediction still holds and that doctors are keeping pace with population growth. It was completed prior to the 2000 US Census, based upon population estimates.

[8] The authors wish to thank Ms. Sue Brown and the Arizona Medical Association for their assistance with the retrieval of data from the Arizona Board of Medical Examiners.

the AzCGME findings for 1990). The adjusted numbers suggest the shortage is actually more acute.

Table 2. Adjusted Physician/Patient Ratio	
In-State Physicians	9,474
Number of Retirees	513
Percent Retirees	6
Number Administrative Physicians	120
Percent Administrative Physicians	1
Adjusted Physician/Patient per 100,000	172

This data does not take into account the number of physicians who maintain active clinical practice but have decreased their hours of work to part-time status. Unfortunately, such information is not collected by the Arizona Board of Medical Examiners or, to our knowledge, any other entity concerned with Arizona physician data. If one assumes that at least a segment of the Arizona physician population in active clinical practice works reduced or part-time hours, then it would be reasonable to assume the physician/patient ratio of 172 is actually an optimistic assessment.

Examination of data from the Arizona Board of Medical Examiners found that the number of licensed physicians listed as "retired" has increased from 5 percent in 1996 to 6 percent in 2000. Those listed as "Administrative" have remained stable at 1 percent during the same time period. We found no significant change in the distribution of doctors among the various specialty categories recognized by the Board of Medical Examiners over the same time period. However, recommended physician-patient ratios for specific medical specialties are not available to us, so it is inappropriate to conclude that the shortage is actually an "across-the-board" shortage of physicians, regardless of specialty. Further investigation may lead to the conclusion that some specialties are more adversely affected by the shortage than others.

Our findings are compatible with a report from the American Medical Association that, as of 1999, the last year for which they had available data, Arizona ranked thirty-second in the nation in the number of physicians per population—a counter-intuitive finding, given Arizona's climate and lifestyle attractions.[9]

With the 2000 Census showing Arizona's population to be aging across all age categories, and the median age (34.2) two years older than the median age in

[9] *Physician Characteristics and Distribution in the US*, Division of Survey and Data Resources, 2001 and Prior Editions. American Medical Association, Chicago, Illinois.

1990, these findings could portend serious problems for future health care delivery in Arizona. As age advances, so does the likelihood of needing medical attention.

Causative Factors

In searching for factors causing the physician shortage, we started with the basic premise that the practice of medicine in Arizona has become less economically attractive. It stands to reason.

When deciding where to locate a business (i.e., medical practice), the first considerations are always economic. Physicians contemplating starting, joining, or relocating a medical practice access various information sources: publications such as *Medical Economics* (published by Dow Jones), newsletters, medical conventions, and word of mouth. They seek information on matters such as compensation, work hours, labor and overhead costs, cost of living, litigation climate, and quality of life. These criteria involve innumerable variables, and it is difficult, if not impossible, to precisely determine how each individual doctor decides where to locate his/her practice. If Arizona fares poorly in one or more of these parameters, it follows that this would impact the prospective doctor's decision. Arizona is one of the fastest growing states in the union. It provides an appealing environment to many segments of the American population. The fact that Arizona does not seem to have an equally strong attraction to the medical profession suggests that economic considerations are the principal factor, all other Arizona attributes being equal.

With the litigation climate in Arizona relatively stable over the past five years, and the relatively low cost of living still one of Arizona's positive attributes, compensation for hours worked appears to be the factor most worthy of investigation. We started by looking at some crucial aspects of Arizona's health care consumer population that can lead to decreased physician compensation for hours spent:

1. *HMO Penetration Rate*—because HMOs negotiate substantial discounts from doctors for services rendered, and have little if any out-of-pocket costs to consumers (therefore little feedback on demand), one would expect a population with heavy HMO penetration to result in lower compensation for hours worked.

2. *Medicare Penetration Rate*—because Medicare reimburses doctors at roughly 35-40 percent of their usual and customary fee (with doctors having to "write off" the balance), and because the Medicare-age population is more likely to have complicated and serious illnesses requiring a large time investment by the health care provider, one would expect a population with heavy Medicare penetration to result in lower compensation for hours worked.

3. *Medicaid Penetration Rate*—Medicaid also reimburses providers at reduced rates, and the indigent population on Medicaid has a higher incidence of serious health problems. For these reasons, a high Medicaid population should also lead to lower compensation for hours worked.

4. *Uninsured Rate*—most people who lack health insurance are unable or unwilling to pay for major medical services. These days, unfortunately, "uninsured patients" translate into "uncompensated care." *Cost shifting* of the uncompensated care by the providers to those with good insurance coverage through increased fees is restricted these days: HMO, PPO, and other managed care contracts restrict the provider to an agreed-upon fee schedule; Medicare and Medicaid have government enforced price controls on physicians' services.

Utilizing data provided by the Kaiser Family Foundation's "State Health Facts Online," we found the following: [10]

1. *HMO Penetration Rate*—Arizona's HMO penetration rate is 31 percent. Arizona ranks 17th in the US in HMO penetration, tied with Florida and New Jersey. The national HMO penetration rate is 30 percent. California leads the nation in HMO penetration (54 percent). Massachusetts (53 percent), Connecticut, Maryland, Oregon, and Colorado are 2nd through 6th respectively, all having greater than 40 percent penetration. Mew Mexico is 7th with 38 percent penetration, and Nevada is 25th, with 23 percent penetration. These findings reveal nothing that suggests Arizona has an HMO penetration rate at any major variance with much of the country. It certainly compares well with neighboring states or states with similar attributes. The data are for the year 2000.

2. *Medicare Penetration Rate*—Arizona's Medicare penetration rate is 12 percent. It ranks 17th in the nation, tied with eleven other states. The national Medicare penetration rate is 11 percent. California's is 9 percent. Florida's is 17 percent. Nevada's is 11 percent. Again, nothing in the data suggests that Medicare penetration in Arizona is in any way extraordinary. (Data for 1977-99.)

3. *Medicaid Penetration Rate*—The national Medicaid penetration rate is 10 percent. Arizona's is 9 percent. It ranks 26th. California's is 13 percent. Nevada's is 6 percent. Tennessee and the District of Columbia lead the nation with 19 percent, New York has 15 percent, and Florida has 9 percent. Once again, nothing in the data suggests Medicaid penetration is a major factor in decreased compensation when compared with other states. (Data for 1997-99.)

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[10] http://statehealthfacts.kff.org—drawing on data from the US Census Bureau, the Urban Institute, Kaiser Commission on Medicaid and the Uninsured, and The Interstudy Competitive Edge 10.2, Part II: HMO Industry Report, October 2000.

4. *Uninsured Rate*—the national percentage of uninsured is 16 percent. Arizona stands out with a 23 percent uninsured rate. This means that almost one in four patients will not have insurance—a significant cause of uncompensated care. It is tied with New Mexico in second place. Texas leads the nation with a 24 percent uninsured rate (but it ranks 29th in HMO penetration, at 19 percent, leaving more room for cost shifting of uncompensated care to those with regular insurance). Nevada has 20 percent uninsured, and California has 21 percent uninsured. New York has 17 percent uninsured. Florida's rate is 19 percent. (Data for 1997-99.)

The data suggest that a 23 percent uninsured rate (nearly one in four patients will not compensate providers for most care rendered), combined with a remaining pool of payers that leave little opportunity for cost shifting, is a major factor making Arizona less economically attractive to doctors than possible.

In order to look at factors contributing to the extraordinary uninsured rate in Arizona, we started by looking at the make-up of the uninsured population.

Arizona's Uninsured Population

Examination of data provided by the Kaiser Family Foundation's "State Health Facts Online" for 1997-99 reveals the following information about Arizona's uninsured in comparison with some other key states and the national average:

Table 3. Distribution of Uninsured by Ethnicity

	AZ	CA	NM	TX	FL	NV	NY	USA
White	18%	15%	19%	16%	18%	18%	13%	13%
Black	22	21	NSD	31	27	19	23	23
Hispanic	43	38	31	40	34	37	35	35
Other	23	23	38	30	22	22	33	24

Table 4. Uninsured Distribution by Federal Poverty Level

	AZ	CA	NM	TX	FL	NV	NY	USA
Under 100%	42%	39%	46%	39%	36%	39%	37%	36%
100-199%	32	31	28	31	27	25	27	29
200% or more	26	30	25	29	37	36	36	35
Under 200%	74	70	75	71	63	64	64	65

Table 5. Population Distribution by Citizenship Status

	AZ	CA	NM	TX	FL	NV	NY	USA
Native	85.0%	74.1%	92.8%	86.8%	80.3%	84.2%	77.7%	89.6%
Naturalized	0.2	0.2	0.1	0.2	1.9	0.6	2.1	3.9
Non-Citizen	14.8	25.6	7.1	13.0	17.8	15.2	20.2	6.5

Table 6. Population Distribution by Race/Ethnicity								
	AZ	CA	NM	TX	FL	NV	NY	USA
White	64%	50%	46%	51%	66%	70%	65%	71%
Black	3	6	2	13	14	6	15	13
Hispanic	29	31	40	32	18	18	15	12
Other	3	13	13	4	2	6	5	5

The states of California, New Mexico, Texas, and Nevada were chosen for comparison to Arizona because, like Arizona, they are southwestern states that share, or are in close proximity to, the Mexican border. Florida and New York were chosen for comparison because they have large immigrant, non-citizen, and Hispanic populations, but differ significantly in geographic location. This difference would be expected to result in immigrant, non-citizen, and Hispanic populations of a different composition than those of the other states listed in the comparison.

Interestingly, Arizona ranks 7th in the nation in percent of non-citizen population. In addition, data from the 2000 US Census ranks Arizona third in the nation with respect to Mexican population as a percent of total state population:[11]

1. California—25%
2. Texas—24.3%
3. Arizona—20.8%
4. New Mexico—18.1%
5. Nevada—14.3%

Florida and New York each have Mexican populations of less than 4.9 percent of total population.

The data tell us that a very major component of the uninsured populations of Arizona, California, New Mexico, Nevada, and Texas are very poor immigrants from nearby Mexico. All of these states either share a border with or are close to Mexico.[12] Many undocumented immigrants from Mexico are not included in this data. They also seek medical attention at hospital emergency rooms, clinics, and

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[11] "Trying Amnesty Again?" *Wall Street Journal*, July 17, 2001, page A20—Graphic.

[12] A recent survey conducted by the California Medical Association entitled "And Then There Were None: the Coming Physician Supply Problem," warns that many of it doctors plan to flee the state or retire early due to low pay and frustration with managed care. This should come as no surprise, in light of California's 21 percent uninsured rate, its proximity to the Mexican border, and the fact that its extraordinary HMO penetration rate (54 percent--national average is 30 percent) leaves little room for providers to "cost-shift" their uncompensated care. *Wall Street Journal*, July 16, 2001, page B8: "California Doctors Warn of Exodus, But Draw Doubts," by Rhonda L. Rundle.

doctors' offices, and lack insurance. Therefore, the percentages of the uninsured population reported in these states may in fact be optimistic numbers.

Arizona's status as a state bordering on a relatively impoverished nation confers stresses upon its health care system that are unique to a handful of states. This means that federal health care policy designed as "one-size-fits-all" has the potential to impact Arizona completely differently than the majority of states.

Policies that Increase the Uninsured Population in Arizona

The Double Whammy

Federal and state health care policies often have the unintended consequence of increasing the number of uninsured. This can occur in various ways.

- The policy can increase the population of uninsured by attracting uninsured to a given geographic region.
- The policy can result in an increase in the cost of insurance, making it unaffordable for many individuals to purchase.
- The policy can result in an increase in insurance premiums, causing employers to drop the health insurance coverage they provide as a benefit to employees.
- The policy can result in an increase in the cost of providing health care, generating an increase in charges to insurers, and thus an increase in premiums charged to employers or individuals.

When policies lead to an increase in the number of uninsured, they hurt the population in two ways:

1. The number of people with inadequate access to health care increases.
2. The resultant increase in uncompensated care makes the market unattractive to health care providers, leading to a net decrease in providers, and thus impeding health care access for the general population.

This "double whammy" is happening in Arizona, and is likely occurring in other states as well. It is important to note that each state has its own unique demographic and socioeconomic context. Therefore, federal health care policy that is applied equally across the nation will have unintended consequences that vary in degree and intensity among the individual states.

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA), passed by the US Congress in 1986, requires, among other things, that hospital emergency rooms give necessary emergency treatment to any person who presents, without any consideration as to that person's ability to pay. Patients *may not* be transferred to other facilities for care, unless they request the transfer, or unless a needed service is not available at the facility to which the patient presents . The physician on call to the emergency room must respond promptly, and must care for the patient. Failure to comply with these requirements can result in severe criminal penalties, monetary and otherwise.

Before EMTALA, most hospitals maintained voluntary emergency room on-call schedules of staff physicians and specialists. However, because of the strict requirements regarding prompt coverage for any and all patients, with the threat of severe penalties to hospitals that fail to comply, many hospitals have found it necessary to make emergency room call mandatory for all staff physicians.

Physicians on call must respond promptly to the emergency room within a defined set of EMTALA guidelines, regardless of the circumstances (e.g., the physician on call might be involved in performing surgery at the time he is called—failure to respond promptly or to send another physician in his place can result in severe federal penalties). This added pressure to the physicians, coupled with the fact that, a significant amount of the time, the care rendered will go uncompensated, has led a great number of doctors to resign from the staffs of all but their most utilized hospitals. As a result, many of Arizona's emergency rooms find themselves unable to find enough doctors to provide the needed emergency room coverage in various specialties.[13]

In a letter addressed to Helene Toiv, Assistant Director of the US General Accounting Office, on April 22, 2001, The Arizona Hospital and Healthcare Association complained that EMTALA is resulting in care delays and bottlenecks, with patients spending more time in emergency departments. It mentioned that the hospitals are having increasing difficulty getting medical coverage for their emergency patients, since doctors are resigning from their staffs. The letter went on to point out that EMTALA is placing a great financial burden on the hospitals, requiring many to cut back services, personnel, or to even consider closing. These financial burdens are caused by the federal requirement that they increase the amount of uncompensated services rendered. The letter also pointed out that the

[13] See "Valley Doctors Shun ERs—Hospitals Scrambling For Help," by Jodie Snyder, *Arizona Republic*, June 3, 2001; see also "ER Woes Not Fault of Law, GAO Says," by Jodie Snyder, *Arizona Republic*, June 26, 2001.

compliance costs of EMTALA, ranging from personnel costs to attorneys' fees, are also adding to the strain.[14]

According to The Arizona Hospital and Healthcare Association (AzHHA), "both insured and uninsured patients are using the emergency department with increased frequency for a huge variety of medical problems, including primary care. (See introduction.) Because so much of this care is uncompensated, hospitals are facing a crushing financial burden."

The AzHHA communication went on to discuss the impact of EMTALA on care for the "illegal immigrant" population: "...this is a huge problem, particularly in the border towns and in Tucson. It was noted that *undocumented aliens routinely move across the border because of their knowledge of EMTALA's requirements* (italics added). This population is rarely insured, thus creating additional financial burdens. The problem of INS agents leaving patients at the hospital rather than maintaining them in custody during the hospital visit was also discussed as a cost-shifting maneuver by the INS...most hospitals on occasion find themselves with patients who need to be transferred, for example, for long term rehabilitation care after emergency treatment at a hospital, but that Mexico, having no such parallel law, does not require its hospitals to take those patients back."

In June of 2001, the US General Accounting Office issued a "Report to Congressional Committees" on the impact of EMTALA on emergency care. While stating that "it is difficult to assess the relative importance of individual factors," the report went on to say that "other factors such as the growth of the uninsured population and the difficulty some managed care patients may have in obtaining timely appointments with their personal physicians, *can also explain* the increase in emergency departments visits..." It went on to suggest that many doctors might be resigning from hospital staffs due to factors other than uncompensated care, "such as the ability to perform procedures in non-hospital settings." There was no objective data offered to support these suggested explanations. Nor was there any attempt to assess the "relative importance of individual factors." (Italics added.)[15]

EMTALA has a major deleterious effect on the delivery of healthcare.[16] But its harmful effects are not distributed equally across the country. It does more damage in states that border on a relatively impoverished nation (particularly

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[14] *Round-Up*, Official Publication of the Maricopa County Medical Society, Volume 47, Number 5, May 2001: "Special Report," pages 12-21. The letter to the Assistant Director of the US GAO from the AzHHA was signed by Sheri Jorden, Senior Director, Regulatory Affairs and Policy, AzHHA.

[15] June 2001, United States General Accounting Office Report to Congressional Committees: "Emergency Care—EMTALA Implementation and Enforcement Issues," (GAO-01-747).

[16] For a more detailed economic and legal analysis of the effects of EMTALA, see *Mortal Peril—Our Inalienable Right to Health Care?* by Richard A. Epstein, pages 91-105.(1997: Addison-Wesley Publishing Company, Inc., Reading, Massachusetts).

states with smaller populations and state budgets, such as Arizona) than it does in states in other regions of the country. EMTALA is increasing the percentage of uninsured by creating an incentive for poor Mexicans in need of medical care to cross the border and access Arizona's healthcare system. It allows Arizona to serve as an "escape valve" for Mexicans who are poorly served by their nation's healthcare system (ironically, Mexico provides universal coverage for all of its citizens). This adds to the amount of care that goes uncompensated, thus making the healthcare market less attractive to hospitals and providers. It also raises the costs incurred by hospitals and providers in their delivery of services. Where cost-shifting is possible, this contributes to an increase in costs to insurers, and ultimately, in the price of health insurance.

Mandated Benefits Laws

Federal and state laws mandate that health insurance meet a variety of requirements. Among those requirements are coverage requirements, i.e., coverage of specific diseases or specific health care services. In recent years, mandates have even dealt with the way medicine is practiced. For example, there are now hospital length-of-stay mandates for obstetrical care and mastectomies. In 1970 there were only 48 such laws in the US. By 1988 there were over 1000.[17]

State mandated benefits, along with other state regulations, are increasing the cost of health insurance and pricing one out of every four uninsured people out of the market.[18] Mandated benefits laws increase the cost of health insurance by increasing the amount of services the insurance is required to cover. The increased cost of health insurance has been shown to cause a net decrease in wages at the same time that it prevents individuals from buying cheaper, less comprehensive health insurance policies—another example of the "double whammy."[19]

The "Patients' Bill of Rights" under consideration in the US Congress amounts to a large expansion of the federal mandated benefit laws. Its features allowing patients to sue their health plans or their employers for medical malpractice committed by the plans' contracted health care providers would even more severely increase the cost of providing health insurance. Just the threat of lawsuits is enough to significantly raise premiums. The threat of litigation will cause health plans to practice "defensive medicine," i.e., lift most restrictions on tests and procedures desired by patients or their providers for fear of getting sued. The resultant increase in costs to the health plan leads to premium increases. Recognition and anticipation of the phenomenon of defensive medicine provides

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[17] John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," NCPA Policy Report No. 134 (Dallas: National Center for Policy Analysis, November 1988).

[18] John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis,* (Washington, DC: Cato Institute, 1992), page 354.

[19] "The Incidence of Mandated Maternity Benefits," by Jonathan Gruber, *American Economic Review,* Volume 84, Number 3, 1994: pages 622-41.

enough justification for insurers to raise premiums in states that have enacted "right to sue" laws, regardless of the amount of lawsuits actually taking place.

The premium increases resulting from "Patients Bill of Rights" legislation would serve to make it even more unaffordable for the uninsured to purchase health insurance. What's more, many employers might decide to stop providing health insurance benefits to their employees, due to the increased cost of the insurance as well as fear added liability risks.

A study by the Employment Policy Foundation compared two "Patients' Bill of Rights" proposals under consideration by Congress during the summer of 2001. One proposal (H.R.2315) allows for litigation, but is more restrictive than the second proposal (S. 1052). While it found that both bills would lead to an increase in the number of uninsured, the study found that 2 million fewer persons will be covered by insurance in 2010 as a result of the House bill, while there will 9 million more uninsured as a result of the Senate bill.[20]

An actuarial analysis by the Health Insurance Association of America was more optimistic.[21] It projects an increase of 6.5 million uninsured if the Senate version of the "Patients' Bill of Rights" passes. The main reason, according to HIAA, is that the number of employers offering health insurance coverage in 2003 likely would decrease by a conservatively estimated 5 percent, compared to the number of employers likely to offer coverage in 2002. Some 6.5 million Americans would lose their employer-sponsored health insurance. Of these, 3.7 million would become uninsured, while many of the remaining 2.8 million would likely enroll in public programs, such as Medicaid or a state Child Health Insurance Program ("S-CHIP") -- thereby increasing costs to taxpayers. The most severely affected would be low-income workers and their families.

Nearly half (46 percent) of employees with incomes under 200 percent of the federal poverty level working for employers who drop coverage would become uninsured, while only 7 percent of these workers would retain private coverage.

Tax Code Inequities

The federal income tax code has the unintended consequence of rewarding patients for seeking health insurance coverage through their employer, while punishing those who do not receive employer-provided health insurance. Employer-provided health insurance is not subject to income or payroll taxes, and is therefore a tax-exempt benefit. According to the Congressional Budget Office, this amounted

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[20] NEWS RELEASE: " There's a Big Difference in the Patients' Rights Legislation Before Congress," July 12, 2001, and "Patients' Rights Legislation: The Triangle of Health Insurance: Quality, Cost and Access," Policy Backgrounder, June 20, 2001, both Employment Policy Foundation, Washington, DC

[21] "A State-by-State Analysis of the Newly Uninsured," Health Insurance Association of America, July 18, 2001. For HIAA texts: http://www.hiaa.org/news/newsstate/010718PressConference.htm.

to more than $74 billion in tax subsidies to corporate America in 1994 alone—at the same time, federal tax law prevented any of that subsidy from going directly to individuals.[22]

Individuals wishing to purchase health insurance must do so with "after-tax" dollars. Therefore, the federal tax code has the perverse effect of punishing those who generally can least afford health insurance (those in the kinds of low-paying jobs where health insurance is not provided by the employer), by removing the favored tax status conferred upon those whose jobs provide health insurance.

The current tax code, by encouraging employer-provided health insurance, has additional deleterious effects: it allows employers—not consumers—to select health care benefits; it is a principal cause of "job-lock," wherein an employee becomes "trapped" in an unwanted job for fear of loss of health insurance.

Policy Prescriptions

Policy reforms that serve to decrease the number of uninsured patients in Arizona will also serve to mitigate the rate of uncompensated care. This will have the dual effect of enhancing access to health care for all Arizonans, and creating a more friendly and attractive market for health care providers—thus, hopefully, alleviating the physician shortage.

Experience has taught us that centralized, "command-and-control" approaches to public policy have unintended consequences—and those unintended consequences are often of unequal distribution. Many of the problems faced by Arizona's patients and health care providers are the direct result of centralized, "one-size-fits-all" public policy. An old adage states that when one finds oneself dug into a deep hole, the first thing to do is stop digging. With this in mind, we offer the following policy prescriptions.

Repeal the Emergency Medical Treatment and Labor Act (EMTALA)

Repeal of EMTALA would help to end Arizona's role as an "escape valve" health care provider for people living in Mexico. This, in turn, would go a long way towards attacking the problem of uncompensated care. In addition, by removing the financial burdens (not to mention the real fear of federal criminal sanctions) EMTALA imposes on hospitals and doctors, repeal would improve market conditions for both.

Hospitals and doctors have a long tradition of providing charity care to those unable to pay for their services. But, over the years, various healthcare communities have worked out their own solutions—each solution best suited to the

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22 "Restoring Health Freedom: The Case For a Universal Tax Credit for Health Insurance," by Sue A. Blevins, Policy Analysis 290, December 12, 1997, Cato Institute, Washington, DC.

individual community, and always voluntary—to the problem of providing care to the uninsured. The experience of the past century has taught all but the most intransigent of policy makers that spontaneous solutions, arrived at by civil society, specific to the individual community's context, always work best. Without EMTALA, the uninsured will still get care—as they did before EMTALA. But communities will be able to develop less burdensome methods for providing this care when free from the centralized mandates of EMTALA.

End or Phase Out Mandated Benefits Laws

Mandated benefits laws have been shown to increase the cost of health insurance and consequently increase the number of uninsured. Mandated benefits laws, by increasing the cost of health insurance, erect a large barrier for those with marginal incomes who wish to purchase individual insurance.

Many individuals would be very well served by simple, catastrophic insurance policies that meet their specific health care needs. But mandated benefit laws require them to purchase insurance that provides many benefits they don't need and don't wish to purchase. So they go without insurance.

Repeal of mandated benefits laws will make it easier for those who do not receive health insurance as an employment benefit to purchase health insurance on their own—especially since they are forced to do so with "after-tax" dollars.

At the very minimum, no new mandated benefit laws should be enacted.

Expand and Remove Restrictions from Medical Savings Accounts

When tax-preferred medical savings accounts (MSAs) were allowed to be created by the Health Insurance Portability and Accountability Act of 1996, strict limitations were placed on the amount of policies that could be sold. In addition, rigid requirements were imposed on the deductibility limits of the catastrophic insurance component of MSAs, as well as on who can contribute (and how much) to an MSA in any given year. This has resulted a very small segment of the population (roughly 100,000) establishing health insurance coverage through medical savings accounts.

Despite this fact, MSAs are a very sensible and promising way of providing low cost coverage to those who can't afford health insurance premiums. US Treasury figures for 2000 revealed that of the nearly 100,000 Americans who purchased MSAs since the pilot program began in January 1997, more than a third were previously uninsured.[23]

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[23] "MSAs Deserve a Healthy Boost," Senator Robert Torricelli, *Wall Street Journal*, op-ed column, July 28, 2000.

Experience in South Africa, where MSAs were introduced under Nelson Mandela in the 1990s, have been very encouraging. Currently, more than half of those who have private health insurance in South Africa have it in the form of an MSA. Since the South African government never passed a law dictating MSA design, MSAs developed in a relatively free market. They are less restrictive and, in some ways, more attractive than the American version.[24]

Congress should enact legislation making MSAs available to everyone, allowing MSAs to be combined with any health plan, and allowing more flexibility in deductibles and contributions. MSAs can serve an important function in decreasing the number of uninsured.

Defined Contribution Alternatives to Health Insurance

An intriguing and under-utilized portion of section 106 of the IRS Code allows an employer to extend the advantages of tax exclusion to employer defined contribution plans. The employer may choose to reimburse employees for some or all of the health insurance premium expenses they incur when the latter select other health plans that are not sponsored by the employer. This fixed reimbursement under a defined contribution approach remains tax-advantaged only if the employer makes those premium reimbursements directly to the employee's insurer, without the money passing through the employees hands.

This allows employees to purchase individually owned insurance while avoiding the negative tax consequences of such a move. It also allows employers to provide insurance to employees at less cost and risk.

Congress should further clarify the tax treatment of employers' defined contribution payments and remove other regulatory uncertainties. This would accelerate the move to an environment in which workers more directly control their health care benefits and insurance choices. It would promote economic forces aimed at lowering the cost of health insurance coverage.

Facilitate Association-Based Insurance

Employees covered by the health insurance plans of large corporations not only benefit from being part of a large insurance pool, but they receive advantages under federal law and the tax code that are not afforded to those who do not have employer-provided insurance. One advantage is that they are covered by the Employee Retirement Income Security Act, or ERISA.

Among other provisions, ERISA exempts corporate health plans from expensive state mandates. It also protects employers from certain law suits,

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[24] "MSAs for Everyone, Part I," by John C. Goodman, Brief Analysis 318, March 31, 2000, National Center for Policy Analysis, Dallas.

although that protection will be weakened if the patients' bill of rights is passed by Congress.

The disadvantage of employer-provided insurance is that it makes employees dependent on their employers for medical care. A change in employment status results in a change in insurance status.

While it can be argued that under federalism the federal government should not interfere with state prerogatives in regulating health insurance, the reality is that ERISA and other federal legislation and regulations are not going to be rescinded. Therefore, it is only fair that ERISA-like protection be given to those who are not covered by employer plans.

Specifically, that protection should be extended to association-based plans as a way of facilitating the development of such plans. An association-based plan is a group plan offered by a fraternal, religious, professional or charitable organization to its members. Such insurance would stay in effect for as long as the insured individual remains a member of the association. And since most associations are nonprofit organizations, association-based insurance would not have what some see as the conflict of interest between profits and patient care.

Association-based insurance has great potential for addressing the health insurance needs of Mexican immigrants in Arizona. Since the majority are devout Catholics, their association of choice would undoubtedly be their local parish or diocese, if the Catholic Church were to offer group health insurance. Given the Church's mission of helping the sick and the poor, that would seem to be a natural role that the Church would want to play, as long as it would have ERISA-like protections. The Church would not have to be in the insurance business and carry the risk, just as many corporations do not carry the risk. The corporations are intermediaries who use their group purchasing power to buy insurance from insurance companies, who both underwrite and administer claims.

Enact a Universal Tax Credit for Health Insurance

A good way to reverse the inequities in the existing tax code while making insurance more affordable to all, is to enact a universal tax credit for health insurance.[25] Unlike current tax exemptions, a universal tax credit neither discriminates against those who purchase health insurance individually, nor rewards those who paid for health care services through insurance rather than directly out of pocket.

The credit amount should be a flat amount for all taxpayers. Capping the total amount of the tax credit minimizes the amount of distortion caused by granting a tax preference to health care as opposed to other goods or services. It

[25] Blevins, "Restoring Health Freedom," pages 17-20.

could be made budget neutral by eliminating the tax exempt status (in effect, a tax subsidy) conferred upon employer-provided health insurance.

The tax credit would go directly to the individual, for the individual to use for the purchase of health insurance and other health care services that best suit that individual. The tax credit can be designed as a refundable tax credit for those whose income tax liability is such that they wouldn't otherwise qualify for a tax credit.

In this way, nearly anyone who wants insurance coverage can get it. But a centralized, "command-and-control" approach to health insurance coverage is avoided. The insurance coverage is individually-owned, customized to the needs of the consumer, and provided by the private sector. Furthermore, the insurance coverage will be the choice of the patient, not the employer or the government. And it will not be tied to the job.

Reform Immigration

Although immigration is good for the economy in the long-run, it does have short-term costs. Many of those costs are borne by Arizona's health care providers, including physicians, who are not compensated for treating the high percentage of uninsured among recent immigrants, especially undocumented immigrants.

For example, the Yuma Regional Medical Center, a relatively small hospital near the Mexican border, estimates that its uncompensated care for undocumented Mexicans was at least $2 million last year.[26] The total for the state is unknown, since hospitals do not ask for proof of citizenship, and no agency is estimating what the statewide cost might be.

The hidden economy of undocumented immigrants not only results in hidden costs for health care providers but also forces the immigrants to live in an underground world where their options for obtaining medical insurance are limited. Denying that the problem exists does not make it go away.

Reforms are needed to bring the hidden economy to the surface, where the short-term problems associated with immigration can be addressed by policy makers on both sides of the border. One reform might be a guest worker program, in which Mexican workers could freely cross the border for jobs in the United States, yet stay eligible for Mexico's national health care system and return home for non-emergency treatment. Alternatively, once the workers have a legal standing—once they are integrated into the legitimate, mainstream economy—they could participate in the medical insurance market to the same extent as American citizens.

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[26] Based upon conversation between Craig J. Cantoni and the Chief Financial Officer of Yuma Regional Medical Center.

It is not within the scope of this report to provide detailed policy prescriptions for reforming immigration, but it is clear that the problems of the uninsured and uncompensated care in Arizona will not be solved unless immigration policy is reformed.

Summary and Conclusions

Arizona has developed a shortage of physicians relative to its population requirements. This shortage has developed over the last ten years.

Arizona's physician shortage is caused by several factors:

- 60 years of misguided government policies have kept a consumer-led free market in medical insurance from developing. Thus the costs of health care and health insurance are greater than they would otherwise be. This ultimately increases the amount of people who are without health insurance coverage and seek uncompensated care.
- Regulations and government price controls have forced physicians to often provide care for less than the cost of the service and many times for free.
- The federal government's immigration policies have created a hidden economy and forced recent immigrants to seek free health care, the hidden cost of which is borne by physicians and other health care providers.
- Compulsory uncompensated care amounts to a real, albeit hidden, added tax on health care providers—and taxation of an activity is a clear disincentive to engaging in that activity.

These factors have combined to make Arizona less economically attractive to health care providers.

Furthermore, since a considerable portion of the uninsured population receives medical care from physicians in hospital emergency rooms instead of private physician offices, there are fewer private physician practices than there would otherwise be in the state. That in turn results in fewer physicians being attracted to the state to staff those practices. In other words, health care and immigration policy have created a disequilibrium in the supply and demand of physicians.

In the past, these problems have been addressed in a way that has made the problems worse. The problems have worsened because the past practice of providing free insurance and uncompensated care to the uninsured does nothing to address the underlying root problem. The root problem can only be solved by making medical insurance more affordable and available through free market reforms. And

those reforms have to be coupled with immigration reforms, especially in border states like Arizona.

Th Authors

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Arizona Hospital and Healthcare Association

Arizona Hospitals: A Financial Snapshot

	1998	1999	2000	2001
Operating Margins				
Maricopa	2.6%	0.2%	-1.4%	1.1%
Pima	-0.4%	-2.6%	2.4%	1.7%
Non-Urban	10.9%	5.9%	9.3%	9.4%
Overall	2.5%	0.0%	.9%	2.5%
Number Reporting:	28	29	34	33
Percentage Losing Money:	**36%**	**45%**	**38%**	**30%**

Comments

- Financial experts recommend that a healthcare organization strive for a 5% margin in order to remain viable and keep up with technological and market demands. In a high growth state like Arizona, this is particularly important. Of the reporting hospitals, 30% posted a negative operating margin in 2001
- In Maricopa County 40% of hospital systems lost money from operations in 2001. In Pima County 33% of hospitals posted negative operating margins.

F:\Jim\Member Surveys\Financial Snapshot 1998-2001

AHA Advancing Health in America

TRENDWATCH

June 2002, Vol. 4, No. 3

Medical Liability Insurance: Looming Crisis?

Health care providers are becoming increasingly concerned about their ability to find affordable medical liability insurance and the effects on access to care. Since 2001, many physicians have faced premium increases in the double digits — as high as 81 percent according to some insurers.[1] High-risk specialities, like obstetrics/gynecology and neurosurgery, are most affected. Premiums for some hospitals have more than doubled.[2]

The magnitude of the premium increases varies across geographic areas due, in part, to differences in legal practices, the regulatory environment, and the number of insurers serving the market. The exit of St. Paul, one of the nation's largest medical liability insurers, is leaving an estimated 750 hospitals and 42,000 physicians scrambling to find new coverage as policies expire.

Hospitals and physicians are responding in various ways. Some hospitals are assuming more financial risk by increasing deductibles, reducing coverage, or self-insuring. Other actions are having an impact on access to care, according to press reports and a limited survey of hospital risk managers conducted by AHA/ASHRM. Some physicians are retiring or relocating to areas with lower premiums, and hospitals are reporting increased difficulty securing physician coverage. Some providers are also cutting back on high-risk services, such as delivering babies or certain types of surgery.

This edition of TrendWatch examines factors influencing the cost and availability of medical liability insurance, the implications of recent trends for patients and providers, and potential solutions to key problems through changes in tort law and other means.

Professional liability premiums are increasing sharply for physicians and hospitals...

*Chart 1: Medical Liability Insurance Rate Increases, Highest States, as Reported by Selected Insurers, 2001-2002**

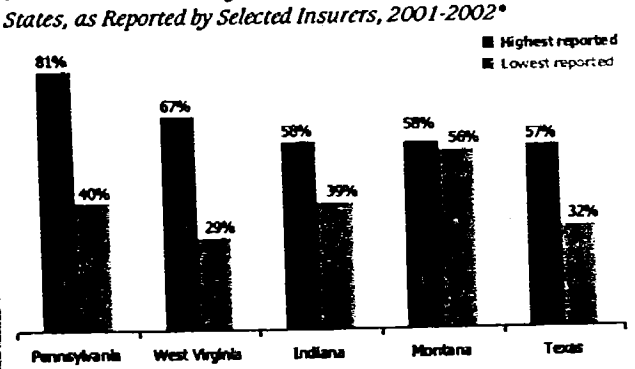
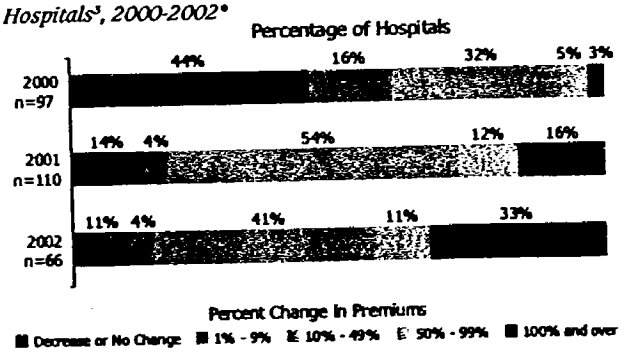


*Chart reflects rate increases for internal medicine, general surgery, and Ob/Gyn physicians.

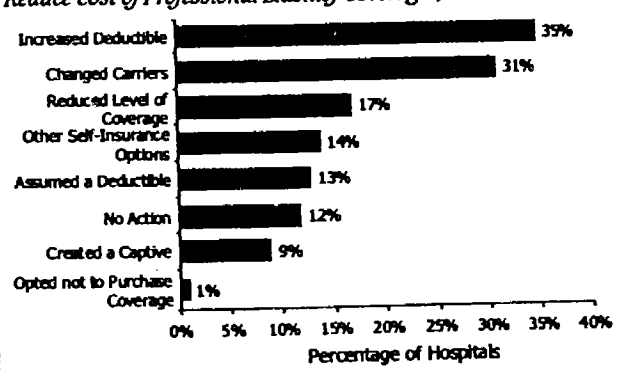
*Chart 2: Distribution of Premium Change for a Sample of Hospitals[3], 2000-2002**



*Results from an American Hospital Association/American Society for Healthcare Risk Management/(AHA/ASHRM) Survey of Hospital Experience with Professional Liability Insurance. Not all respondents provided data for all years.

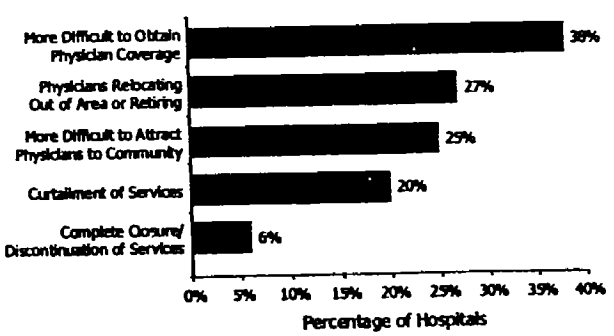
...forcing hospitals to assume more risk and affecting access to care for physician and hospital services.

*Chart 3: Percentage of Hospitals Reporting Actions Taken to Reduce Cost of Professional Liability Coverage[4], 2002**



*Results from an AHA/ASHRM Survey of Hospital Experience with Professional Liability Insurance (n = 132).

*Chart 4: Percentage of Hospitals Reporting Impacts of Current Professional Liability Market on Health Care Delivery[4], 2002**



*Results from an AHA/ASHRM Survey of Hospital Experience with Professional Liability Insurance (n = 132).

The Lewin Group

At the "Crisis" Point of the Insurance Cycle, Insurers Increase Premiums or Leave the Market

While the number of professional liability payment reports has remained fairly stable, the amount paid per claim has been increasing. From 1999 to 2000, the median jury award rose 43 percent to hit $1 million. Though sizeable jury awards tend to get media attention, the majority of claims that are paid are actually settled out of court. The median indemnity paid — an amount that reflects both jury and out of court settlements — increased by 58 percent since 1996.[1]

Meanwhile, insurers have seen their non-premium revenues decline. Investment income is an important source of revenue for medical liability insurers. During the mid-nineties, the booming stock market and relatively high interest rates provided revenue that allowed insurers to offset underwriting losses as the underlying costs increased. Now, with a depressed stock market, interest rates at their lowest point in 40 years, and rising claim dollars, many insurers have implemented sharp premium increases to counteract growing losses or have exited the business of providing medical liability insurance entirely.

The medical liability insurance market tends to run in cycles. The long time lag between when premiums are collected and when claims are paid allows new entrants to offer low rates to gain market share, drive older insurance companies out of the market, and still make above market short-term profits on invested premium dollars. As their claims portfolios mature, however, these new entrants begin to experience losses forcing them to either increase rates dramatically or face insolvency. This attracts another round of new entrants initiating another underwriting cycle.

A number of factors differentiate the current crisis from others in the past. The unprecented insurance industry losses from the September 11, 2001 terrorist attacks and declining returns on invested assets potentially affect insurer decisions to enter or exit the medical liability market. In addition, the dominant forms of medical reimbursement today — prospective payment, contracted fee schedules, and capitated rates — have limited providers' ability to absorb these sudden increases in premium costs.

While the number of medical liability reports has remained stable, the size of jury awards has escalated...

Chart 5: Number of Physician Medical Liability Payment Reports[2] (in thousands), 1996-2000

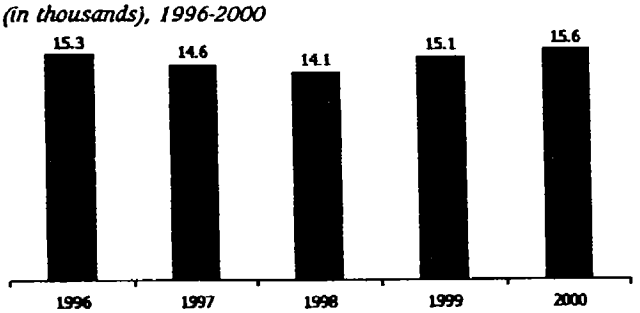
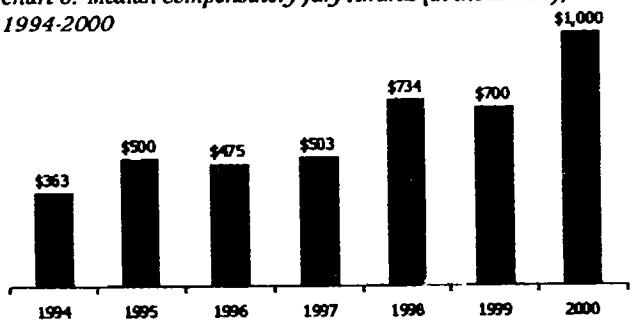


Chart 6: Median Compensatory Jury Awards (in thousands), 1994-2000



...contributing to rapid growth in the size of claims paid by insurers. As insurer expenses have risen, a declining return on invested assets has driven non-premium revenues down.

Chart 7: Median Indemnity Paid, Combined Specialties (in thousands), 1996-2000

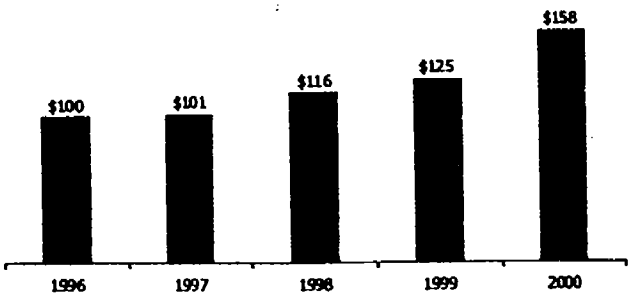
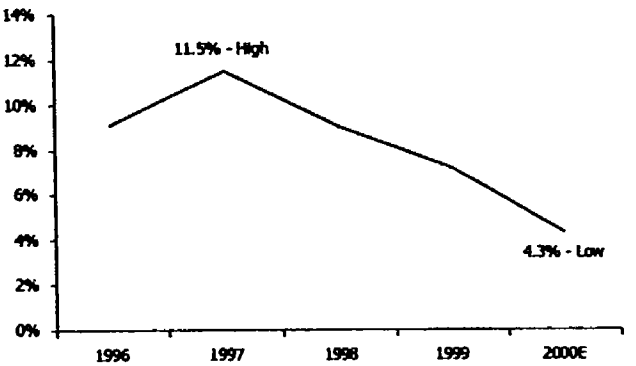


Chart 8: Average Return on Invested Assets, Property and Casualty Insurers, 1996-2000E



TREND WATCH

Premium Levels Vary Widely Across Specialties and Geographic Areas, Which Can Affect Access to Care

Liability premiums vary widely both across specialties and across geographic areas. These differences relate to historical and expected claims experience.

Premium rates are highest for neurosurgery, cardiovascular surgery, Ob/Gyn, and other procedure-based specialties because risk of an adverse outcome is higher. These specialties are affected more by recent trends because medical liability costs comprise a larger proportion of practice expenses than for other types of physicians. Medical and diagnostic subspecialties tend to have lower premiums because the risk of an adverse outcome is significantly lower.

Factors influencing wide geographic differences in premiums include state regulations (see page 4), characteristics of physician organization, local culture and legal practices, differences in the costs of defending claims, population size, and degree of competition among insurers in the market. The exit of a large insurer, like St. Paul, from a market can push premium rates up and make coverage harder to find. In response, physicians may leave for another market and hospitals may need to alter the services they provide.

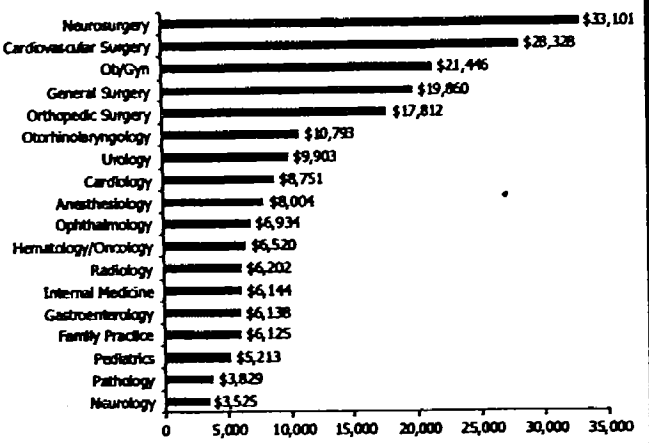
The American College of Obstetricians and Gynecologists has identified nine states — Florida, Mississippi, New Jersey, New York, Texas, Washington, Nevada, West Virginia, and Pennsylvania — where premium costs have tripled or quadrupled for some providers and coverage has become difficult to find.[1] High premiums and resulting income shortfalls have affected Ob/Gyns to the point that some have stopped delivering babies, curtailed surgical services, or shut their doors entirely.

Physicians who treat "high-risk" patients are not the only providers affected. Hospitals are affected because they sometimes absorb premium and litigation costs for certain clinical staff and/or may lose important lines of service. *The Los Angeles Times* reported on scaled-back trauma services in communities in Nevada and West Virginia as rising premiums affect the availability of neurosurgeons and trauma specialists. *The Philadelphia Inquirer* reported that Thomas Jefferson University's Methodist Hospital decided to close its labor and delivery ward, citing "...soaring malpractice insurance costs facing doctors and hospitals."

"It is widely acknowledged that Ob/Gyns along with neurosurgeons and orthopedic surgeons are sued more frequently because of their high risk clientele. Ob/Gyns are especially susceptible because of the intense emotional significance of birth." — Michelle A. Bourque, JD, Defense Lawyer, American Bar Association

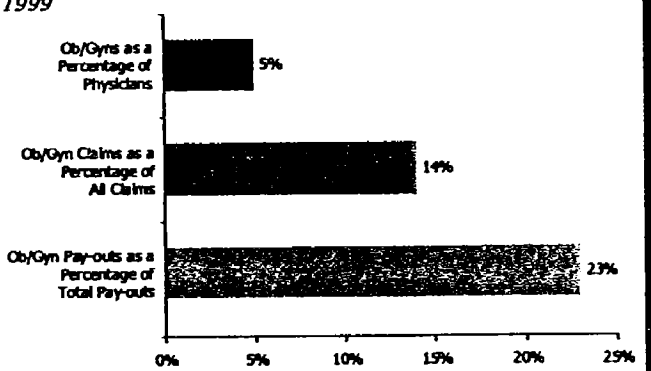
Medical liability expenses vary across specialties...

Chart 9: Median Professional Liability Premium Rates by Specialty, 2000



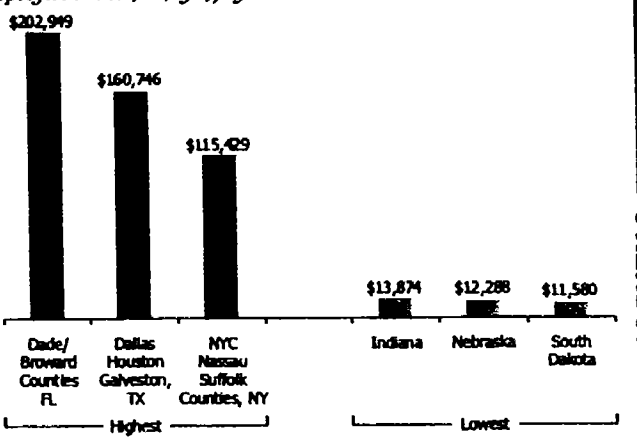
...due to differences in risk and claims experience.

Chart 10: Ob/Gyns as a Percentage of Physicians, Claims, and Pay-outs, 1999



Premiums also vary widely across cities and states.

Chart 11: Highest and Lowest Premium Rates Reported by Insurers in Specific Markets, Ob/Gyn, July 2001



Providers and Insurers Call for Medical Liability Reform As One Way to Address Increasing Premiums

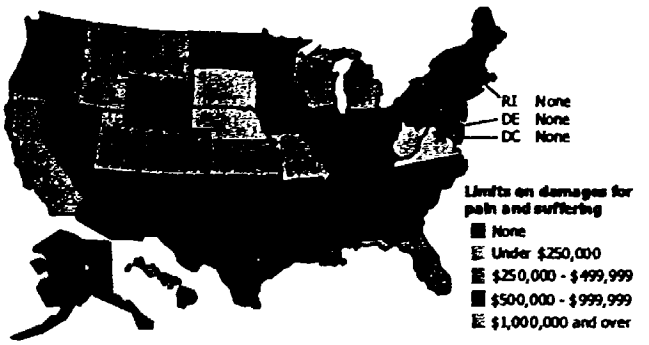
Provider and insurer groups have called for liability reform as one way to address rising costs despite opposition from consumer and attorney groups. Legislative action has mainly occurred at the state level where regulatory authority for insurance matters typically resides. Types of reform include:

- **Limits on non-economic damages:** limits amount that an injured person can receive for pain and suffering;
- **Collateral source payment rules:** allows defense to introduce evidence of payments a plaintiff may be receiving from other sources;
- **Statute of limitations:** limits time for filing claims;
- **Alternative dispute resolution:** provides mechanisms to prevent cases from ending up in court;
- **Limits on attorney contingency fees:** limits the portion of the payment or the dollar amount that an attorney can receive;
- **Penalties for frivolous suits;** and
- **Joint and several liability reform:** holds defendants liable for only their share of damages when multiple parties are involved (e.g., physician and hospital named as defendants).

In addition to supporting liability reform, providers are taking other actions to mitigate the effects of premium increases and manage risk. Providers and industry groups are developing and implementing "best practices". Some providers are choosing to self-insure or create captives in order to share risk among small groups of providers and to reduce their reliance on commercial carriers.

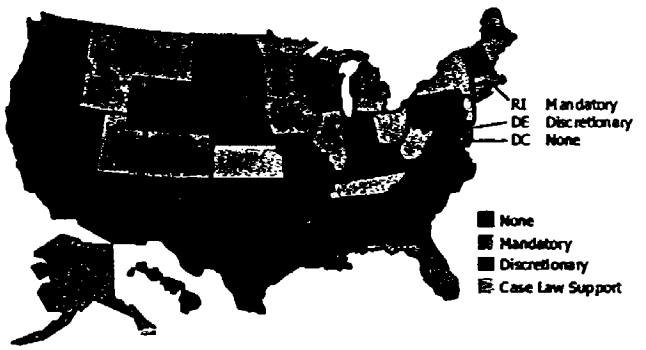
Some states have capped awards for pain and suffering...

Chart 12: Limits on Damages for Pain and Suffering,[1] 2001



...and taken measures to prevent plaintiffs from collecting from multiple sources.

Chart 13: Reform of Collateral Source Rule, 2001



The movement for tort reform is receiving more support at the federal level, in part because a number of state constitutions, like those governing Ohio and Washington, prohibit certain types of reforms, such as limits on damages.

Attempts at tort reform have been made at the federal level, as well (2000-2002).

Bill	Date Introduced	Limits on Non-economic Damages	Collateral Source Payment Offsets	Statute of Limitations	Mandatory Alternative Dispute Resolution	Limits on Attorney Contingency Fees	Penalties for Frivolous Suits	Joint and Several Liability Reform
H.R. 4600 "Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002"	April 25, 2002	✓	✓	✓ 3 yrs after injury		✓		✓
S. 1370 "Common Sense Medical Malpractice Reform Act of 2001"	August 3, 2001	✓	✓	✓ 2 yrs after discovery		✓		✓
H.R. 2103 "Medical Malpractice Rx Act"	June 7, 2001	✓	✓	✓ 5 yrs after injury		✓		✓
H.R. 1639 "Common Sense Medical Malpractice Reform Act of 2001"	April 26, 2001	✓	✓	✓ 3 yrs after injury		✓		✓
H.R. 5344 "Common Sense Medical Malpractice Reform Act of 2000"	September 28, 2000	✓	✓	✓ 3 yrs after injury		✓		✓

Pennsylvania and California: Studies of Reform

Pennsylvania is struggling with medical liability issues similar to those faced by California in the mid-seventies.

In March 2002, the Governor of Pennsylvania signed into law a medical liability reform bill. Pennsylvania's effort represents the latest in a series of legislative actions taken by the State to alleviate pressure on providers for the following reasons:

- Insurers faced heavy losses when declining returns on investment exposed expenses significantly above premiums collected;
- Large jury awards began to put upward pressure on premiums;
- Changes in Pennsylvania law in the mid-1990s required insurers to increase coverage — from limits of $200,000 in 1996 to $500,000 in 2001 — and drove up premiums; and
- The three largest insurers, PHICO, PIC and PIE became insolvent and no longer offered medical liability insurance.

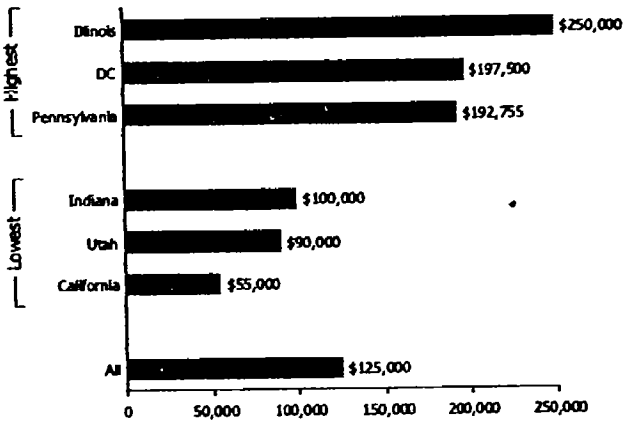
While the law signed in March does not include a cap on damages, it does allow hospitals and doctors to appeal if paying those damages would force a doctor out of business or force a hospital to cut services, thereby affecting access to care in the community. In addition, it allows judgments for future medical costs to be spread out over time, and it incorporates patient protections by requiring hospitals to report medical errors to the State.

Because the effects of tort reform take time to be fully realized, in part due to the long tail of claims, the effects of the legislation in Pennsylvania remain to be seen. But, California, under similar pressure over 25 years ago, implemented sweeping changes of its own in the form of the Medical Injury Compensation Reform Act (MICRA). Physician groups and many other supporters view MICRA as having successfully saved health care dollars, discouraged frivolous claims, and controlled the escalation of premiums while protecting patient access to care and compensating victims of medical errors.

Certain provisions of MICRA face periodic challenges in the California legislature by those who believe that it reduces accountability and creates disincentives for attorneys to represent those harmed by medical errors. Opponents of MICRA support increasing the cap on non-economic damages for those most seriously injured. Thus far, MICRA has withstood those challenges and informed the debate on national reform bills.

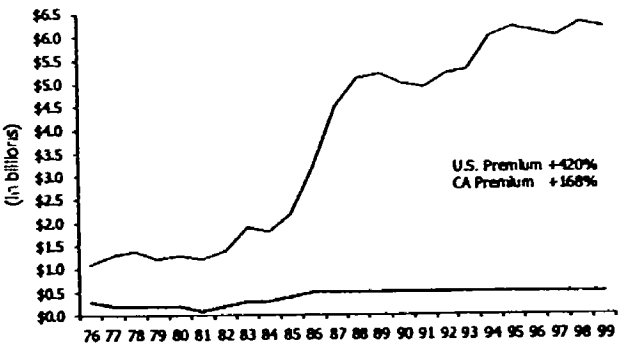
MICRA reforms in California have helped to control increases in payments...

Chart 14: Median Physician Medical Liability Pay-out, 2000



...and premiums.

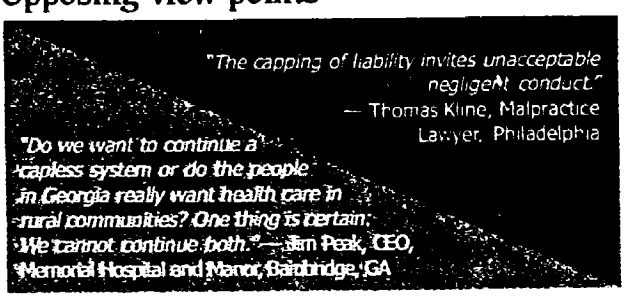
Chart 15: Medical Liability Premiums, CA vs US (in billions), 1976-1999



MICRA Provisions

- Cap of $250,000 on non-economic damages
- Caps on attorneys' fees
- Collateral source rule
- Statute of limitations on filing a suit
- Periodic payments

Opposing view points



Policy Issues and Questions

The current medical liability insurance crisis is likely to drive additional states to implement reform and providers to seek alternative methods of obtaining coverage. Rising premiums and the exit of carriers from the market are having an impact on access to care in some communities. The liability reform debate will continue to evolve as the current crisis unfolds. While premium levels are the focus of current concerns, the medical liability issue also affects the cost and quality of the health care system in other ways. Fearing lawsuits, providers may practice "defensive medicine" ordering more tests than medically justified or take other administrative actions to reduce risk. The punitive legal environment also makes providers less willing to share information on medical errors — information that could be used to prevent future errors.

Questions for policy-makers and providers include:

- How does the current insurance cycle differ from those in the past?
- To what extent will the market failures currently being experienced by certain specialties and certain states become more widespread?
- What immediate steps can be taken to protect access to health care in the areas hit hardest by premium increases?
- How can providers utilize "best practices" to minimize medical errors and better manage risk?
- How can a non-punitive environment be created which encourages the reporting of medical errors and the development of error prevention systems?

Quotes from the Field

"I'm standing ready, willing, and able in a part of the country that is underserved and I can't provide the care because I can't afford the insurance." — Scott Nelson, Family Physician who stopped delivering babies, Mississippi

"Medical liability is one of the most significant problems facing practicing surgeons and their patients. It adversely affects access to and quality of care as well as health care costs." — Samuel A. Wells, Jr., MD, Fellow, American College of Surgeons

"Yes, health care providers do make mistakes at times and yes, there are times when we should pay a claim. But to award somebody hundreds of thousands or even millions of dollars in one settlement, there is no way that a small, rural hospital can stay in business." — Cindy Turner, COO, Bacon County Hospital, Alma, GA

"The alternative is not to practice. For a lot of physicians, that may be a real option." — Deborah McPherson, MD, American Academy of Family Physicians

"It's too much of a medical liability to take calls in emergency rooms. People come in with no prenatal care ready to deliver, and anything can happen. These are the most high-risk patients, and all it takes is one bad outcome to end your career medically." — Bob Comeau, Obstetrician, Clark County, Nevada

Agendas can be obtained via the Internet at http://www.azleg.state.az.us/iagenda/iagenda.htm

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

RURAL PHYSICIANS STUDY COMMITTEE

Date: **Tuesday, January 7, 2003**

Time: **10 a.m.**

Place: **Senate Hearing Room 1**

AGENDA

1. Call to Order
2. Presentation on the Status of Sage Memorial Hospital
   - Lauren Bernally and Jayne Scalise, Sage Memorial Hospital
3. Presentation on the Legal Elements Regarding Malpractice Law Cases
4. Presentation on Other States Facing Malpractice Insurance Crisis
   - Dr. Jim Carland, Mutual Insurance Company of Arizona
5. Presentation on the California Model for Malpractice Reform
6. Public Testimony
7. Committee Discussion
8. Adjourn

Members:

Senator Marsha Arzberger, Cochair
Senator Tim Bee
Dr. Jim Carland
Dr. Brian Grogan
Representative Edward Poelstra, Cochair
Representative Robert Cannell
Chris Chronberg
Alison Hughes

Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602)542-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

JK/cd 01/03/03

ARIZONA STATE LEGISLATURE

RURAL PHYSICIANS STUDY COMMITTEE

Minutes of the Meeting
Tuesday, January 7, 2003
10 a.m., Senate Hearing Room 1

Members Present:
Senator Marsha Arzberger, Cochair
Senator Tim Bee
Dr. Jim Carland
Alison Hughes
Representative Edward Poelstra, Cochair
Representative Robert Cannell
Chris Cronberg

Members Absent:
Dr. Brian Grogan

Staff:
Julie Keane, Senate Health Committee Analyst
Pete Wertheim, House of Representatives Health Committee Analyst

Chairman Arzberger called the meeting to order at 10:08 a.m. and mentioned the changes in Committee members: Senator Bee is replacing Senator Cirillo and Representative Cannell is replacing Representative Clark. She remarked about recent news reports regarding West Virginia doctors walking out on their jobs because of the high costs of malpractice insurance. She explained that the Committee is assessing Arizona's problems regarding malpractice insurance, studying the various approaches used in other states, and seeking workable solutions.

Jayne Scalise, Chief Executive Officer, Sage Memorial Hospital, Ganado, Arizona, distributed a handout (Attachment 1) and provided an overview of the hospital's history and mission, along with four initiatives for the Committee to consider: 1) reciprocity waivers to allow Sage Memorial Hospital to recruit credentialed clinicians, dentists and other healthcare professionals; 2) subsidies to reduce the cost of professional liability insurance; 3) enhanced reimbursement from Arizona Health Care Cost Containment System (AHCCCS); and 4) access to State purchasing contract process for pharmaceutical and other products.

Ms. Scalise noted that the Sage Memorial Hospital is a not-for-profit, private hospital that provides primary medical and dental care to the Navajo Reservation. All other hospitals servicing the reservation are Indian Health Services (IHS) facilities. She referred to two letters in the handout from Dr. Ralph Eccles, Medical Director of Sage Memorial Hospital and Dr. Brad Vargien, Director of Dentistry, outlining the processes of obtaining a medical or dental license in Arizona.

Ms. Scalise pointed out that they currently pay $170,000 for malpractice insurance; however, the rates will increase to $350,000. This increase is due to the region the hospital is in and not because of the risk. She indicated that they are in the process of completing an application to become a critical access hospital and applying for assistance from various sources in order to survive financially.

Senator Arzberger asked for clarification on the regional pricing. Dr. Carland replied that some companies breakdown the losses within geographical areas. In a state with significant tort reform, there is a wide variation in the premiums charged. Senator Arzberger inquired as to what company provides insurance for Sage Memorial. Ms. Scalise replied that they are currently under Banner Health because they were once part of Good Samaritan Hospital. However, when Banner Health purchased Good Samaritan, Sage Memorial was no longer part of their system; therefore, Banner Health will be discontinuing their coverage. Currently, Mutual Insurance Company of Arizona (MICA) is available in their area. She pointed out that they have applied for federal tort reform funds, which should help in reducing the rates.

Ms. Scalise explained that they have diligently campaigned to enroll individuals in the AHCCCS program and noted that they have a cap on funding from the IHS. She also pointed out that they are charged higher rates than the IHS hospitals are charged to transport patients and they are currently seeking discounts in those rates.

Ms. Scalise next referred to a booklet (Attachment 2) which provides historic information on the Ganado Mission, commenting about the various services and lack of many accommodations. She emphasized that although the area is in disarray, they do provide phenomenal healthcare, which covers a population with a high rate of diabetes and all its complications. She also noted that although the hospital provides a safe-ride program, their clinic often has a 50% no-show rate because of the remote rural areas the patients live in.

Representative Poelstra inquired as to how many beds were in the hospital. Ms. Scalise replied that they currently have 45 licensed beds. After February 1, 2003, they will be a critical access hospital with only 25 beds, which is the limited number allowed. Senator Arzberger inquired as to whether that is a sufficient number of beds to serve the community. Ms. Scalise responded yes, because the majority of their work is in outpatient care. She did mention a concern about only having four dentists, which is half of what they had last year.

Ms. Hughes asked for more information regarding the request for enhanced reimbursements from AHCCCS, considering the fact that there has been an increased enrollment in the program. Ms. Scalise answered that currently AHCCCS pays approximately 16% of the cost. In a rural hospital, the overhead costs are higher than in a larger hospital, because the rural hospital still needs all the same departments, just on a smaller scale.

Senator Arzberger asked Ms. Hughes' working group to cover the Sage Memorial Hospital concerns in their report.

Ms. Scalise added that their hospital realized a 30% increase in emergency room care from 1998 to 2002.

In response to Mr. Cronberg's question, Ms. Scalise explained that the costs for ambulances are for noninsured, underinsured and IHS patients. Mr. Cronberg commented that his small rural hospital does not pay transport fees. He also wondered if Sage Memorial was part of a group purchasing program. Ms. Scalise replied that they are; however, it does not significantly help.

Bill Jones, Senior Partner of Jones, Skelton and Hochuli Law Firm, provided some insight into the legal elements regarding malpractice lawsuits. He testified that he has defended doctors and hospitals for approximately 37 years and has been a member of the hospital board for 22 years and also served as Chairman. He pointed out that 65% of hospital costs are from AHCCCS reimbursement, which is a significant problem for the hospitals. He explained that in 1976, Travelers Insurance, who insured most of Arizona's doctors and hospitals, cancelled them all. In response to this crisis, the Legislature passed the Reform Act of 1976, which created MICA. Since that time, Arizona has been a stable malpractice state because of MICA.

Mr. Jones next discussed substantial changes that occurred in the law, one of which is the abolition of what is known as the collateral source rule. One of the problems in malpractice litigation is that medical expenses are being paid multiple times. For instance, in an automobile accident, an individual can have automobile and health insurance, as well as the ability to sue to collect medical expenses. While the jury can be told that the medical expenses have been paid, he said that he feels the awards are not based on those expenses. Mr. Jones pointed out that although the Legislature attempted to stop stale lawsuits by passing a statute that gave injured patients three months to file a lawsuit, that statute was later declared unconstitutional by the Arizona Supreme Court. Another law that the courts eventually declared unconstitutional was the Periodic Payments Act, which allowed payments to be paid over a specific period of time.

Mr. Jones pointed out that malpractice cases are not set on legal standards, rather they are set on medical standards. One of the problems with the medical standards is that they require an expert witness, with some of the witnesses receiving $750 to $2,000 an hour to testify against doctors and hospitals. Some doctors, regardless of their background, have become professional expert witnesses. One thing that can be done to combat this problem is to set criteria for expert witnesses to ensure legitimate experts in the appropriate medical fields are testifying.

Mr. Jones next talked about punitive damages, explaining that they were created by the courts as civil fines to punish wrongdoers. Although Arizona does not have a great number of punitive cases in the medical malpractice arena, those that are awarded are large unregulated damages, which drive up the settlement dollars. He suggested that punitive damages could possibly be abolished or limited to a specific dollar. He

explained that the punishment of an act should be in the criminal courts and not the civil courts, punishing the defendant only once.

Mr. Jones referred to the California Medical Injury Compensation Reform Act (MICRA) of 1975, which he feels is a good system. However, currently Arizona has two constitutional provisions (Article 18, Section 6 and Article 2, Section 31) which prohibit any limitation on the amount of recovery for personal injury or wrongful death. These provisions also prohibit the abolition of any existing cause of action for personal injury or wrongful death.

Mr. Jones explained that Arizona statute indicates that an individual must file a lawsuit within two years of when the injury occurred. However, there are occasions where a patient may not know that a problem occurred for perhaps five years. Currently, a lawsuit can be filed two years from when it was discovered that a wrongdoing had occurred.

Ms. Hughes asked about setting the limits for punitive damages and whether that would be done by the Legislature or courts. Mr. Jones replied that there is a legislative proposal currently being worked on that suggests some standards. Ms. Hughes questioned if this proposal would have an impact on malpractice insurance cost. Mr. Jones responded that some people believe that it would; however, he does not see it as a huge impact.

Mr. Jones noted that there are doctors who have quit practicing after a lawsuit was filed because they feel they have done nothing wrong and feel it is stressful to defend a lawsuit.

Pete Wertheim, House of Representatives Health Committee Analyst, provided a handout (Attachment 3) and expounded on MICRA, noting the medical insurance carrier crisis in the early seventies, in which insurance companies were paying claims in excess of $180 for each $100 collected in premiums. In 1975, two major medical liability insurance carriers did not renew coverage for Southern California and premiums were increased by 380% for Northern California physicians. In May 1975, MICRA was passed to ease this problem by implementing damage caps, providing limits on contingency fees, and allowing for periodic payments.

Ms. Hughes asked if there was any information on the post implementation impact of MICRA. Mr. Wertheim deferred to Dr. Carland who noted that since 1976, California's rates have increased 167%, whereas nationally rates increased by 505%.

Senator Arzberger wondered if a study had been done in Arizona to show what percent of compensation was received by plaintiffs. Mr. Wertheim replied that he will ask the Department of Insurance (DOI) to research that information.

Senator Arzberger mentioned that she had been given some recommendations from a DOI taskforce that is reviewing nursing home medical malpractice and asked if the

analysts would review the data to determine if there is anything pertinent to this Committee. Mr. Wertheim responded that they would do so.

Dr. Carland distributed a handout (Attachment 4) that provides an overview of the malpractice insurance crisis in other states. He explained that the American Medical Association indicates that rising malpractice insurance costs threaten the quality of medical care in 12 states. Indiana, Louisiana, and Wisconsin have passed legislation aimed at reducing these costs. He pointed out that medical malpractice is a huge industry, costing $21 billion annually.

Dr. Carland stated that insurance is a shared risk; it does not create money, it redistributes it. Insurance is regulated by the state and requires capital in excess of premiums to ensure its ability to pay claims.

Dr. Carland noted that indemnity and expense payments are rising dramatically, with settlement values following jury awards which set the benchmark. He mentioned that 15 years ago, jury awards for similar cases were lower in the rural areas than in the urban areas; however, today they are equal. One of the largest amounts awarded in a case was in Winslow.

Dr. Carland indicated that investment income has decreased because insurance rates are down. Interest rates are decreasing; therefore, the subsidization of losses has disappeared. September 11, 2001 cost the insurance industry approximately $50 billion. Adding those losses to the equity market and other catastrophic losses over the past 18 months, the market has lost approximately $205 billion. He pointed out that $28 billion has come back to the market in new funds, leaving a shortfall of $180 billion, which is 22% of the capacity of the property and casualty markets. He suggested that there are fewer companies that have the financial capacity to write new business.

Dr. Carland talked about the immediate consequences of the malpractice crisis, which include: 1) higher premiums; 2) increased nonrenewal and declination of coverage; and 3) hospitals with higher limits impacted the most. Additional concerns include: 1) declining federal and health plan funding; 2) increasing unfunded deferral mandates and illegal immigration; 3) restrictive regulations; 4) increased litigation risk; and 5) aging population demanding brand name prescriptions and state-of-the-art equipment. Dr. Carland stressed that if the people wish to continue unlimited recovery for injuries, then they must pay the necessary fees for healthcare to fund the unlimited liability.

Dr. Carland next discussed some of the results of the malpractice crisis: 1) reduced high exposure hospital services; 2) fewer physicians; 3) limitation of physician services; 4) defensive medicine costs and complications; and 4) equipment purchases deferred or eliminated. He stated that it is his belief that public policy belongs in the Legislature, not in the courts. He said that the Legislature should decide if it is more important to have the needed medical care available; or, if it is more important to have the potential for unlimited recovery, to allow claims filed many years after an injury, to collect multiple

times for the same injury, or to permit claims under the Vulnerable Adult Act against physicians for medical care.

Dr. Carland provided statistics indicating MICA's annual premiums in Arizona for family practitioners, internists, obstetricians, and general surgeons, as well as some national averages for similar positions. He also pointed out which states have the highest rates for malpractice insurance for physicians. He explained that 19 states have caps on the amount of damages that can be awarded in a lawsuit.

Dr. Carland summarized by providing several options for curing the malpractice crisis: 1) do nothing and let the market and courts seek a balance; 2) wait for the federal government to step in; 3) rationalize the process and boundaries of available recovery; 4) subsidize the cost with state funds; or 5) convert to a new system. He expressed his choice would be to rationalize the process and set boundaries for recovery.

Mr. Cronberg suggested that availability is the problem in Arizona where fewer companies are providing malpractice insurance. Dr. Carland admitted that is part of the problem; however, he does not believe Arizona needs more companies to provide more competition. He pointed out that MICA was formed to provide medical malpractice and professional liability insurance in Arizona. He emphasized that MICA is dedicated to Arizona and does not offer any other lines of insurance.

Ms. Hughes referred to Dr. Carland's choice of recommendations that would create boundaries for available recovery, and asked to what extent this would be possible given Article 18, Section 6. Dr. Carland replied that he feels Arizona can do most of what is in MICRA except for the caps. He suggested that they would have to determine how to get around the Supreme Court rulings, which many people feel are inappropriate.

Ms. Hughes noted that he has focused on the comparative costs in other states for special care; however, she wondered to what extent primary care factors into the insurance premium rates. She referred to the federally qualified health centers (FQHC) where there is no capacity to sue and wondered if they could be used as a model. Dr. Carland replied that he is not sure how to answer the last part. He noted that the primary care physicians are the internists, pediatricians and family practitioners. Premiums are set by actuary analysis of where the company has been. Insurance companies look at losses and trends and the rates are set prospectively.

In response to a question from Dr. Carland, Senator Arzberger explained that the working groups are not required to have a chairman. The groups are free to meet at any time and can include other public members. She reviewed the charge of the committee: 1) examine federal and State programs relating to malpractice insurance pools and premium sharing; 2) examine the effect of the cost and availability of malpractice insurance on the practice of obstetrical medicine in hospitals and community health centers in rural Arizona; and 3) review any other information relating to the availability of obstetrical services in rural Arizona.

Senator Arzberger next talked about meeting with Senator McCain and Senator Kyl. Subsequently, she sent a letter to each asking them to address some of the rural problems. Senator Kyl responded and agreed to support increased medical reimbursement. Senator Arzberger had also suggested that the federal government look at extending federal liability insurance to all indigent patients treated in emergency rooms. Senator Kyl replied that he would consider the idea.

Ms. Hughes asked if the working groups had to meet in a public forum or if staff had to be present. Senator Arzberger replied that their only restriction is that they cannot have a quorum of Committee members as part of the working group.

There being no further business, the meeting was adjourned at 11:54 a.m.

Respectfully submitted,

Carol Dager

Carol Dager
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

NAVAJO HEALTH FOUNDATION

SAGE MEMORIAL HOSPITAL
POST OFFICE BOX 457 / GANADO, ARIZONA 86505 / (928) 755-4500

2003 Arizona Legislative Initiatives

January 4, 2003

Executive Summary

Navajo Health Foundation / Sage Memorial Hospital ("Sage") is asking the State of Arizona to enact legislation that will allow Sage to fulfill its mission of providing primary care medical and dental services to residents of the Navajo Nation.

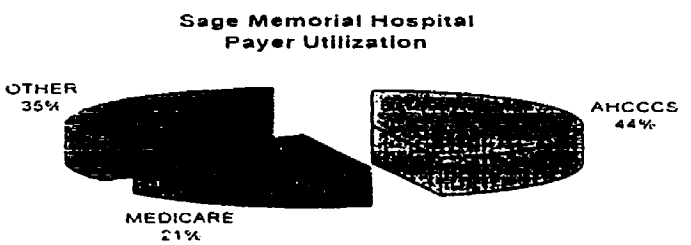
Sage's Board of Directors and leadership are asking the State to consider four legislative initiatives that will benefit Sage and other rural (non-urban) healthcare providers.

1. Reciprocity waivers to allow Sage to recruit credentialed clinicians, dentists and other healthcare professionals;
2. Subsidies to reduce the cost of professional liability insurance;
3. Enhanced reimbursement from the State of Arizona's AHCCCS program; and,
4. Access to State purchasing contract prices for pharmaceutical and other products.

Sage's History and Mission

Sage is a private not-for-profit integrated healthcare system that provides primary care medical and dental care to Native Americans residing within a 50 mile radius of Ganado. In its last fiscal year, patients visited Sage 31,000 times and were hospitalized for 1,750 days.

Sage is accredited by JCAHO (Joint Commission). Sage is awaiting designation as a Critical Access Hospital. This designation, however, will only affect Medicare patients – 21% of our patients. AHCCCS accounts for over 40% of patients served.

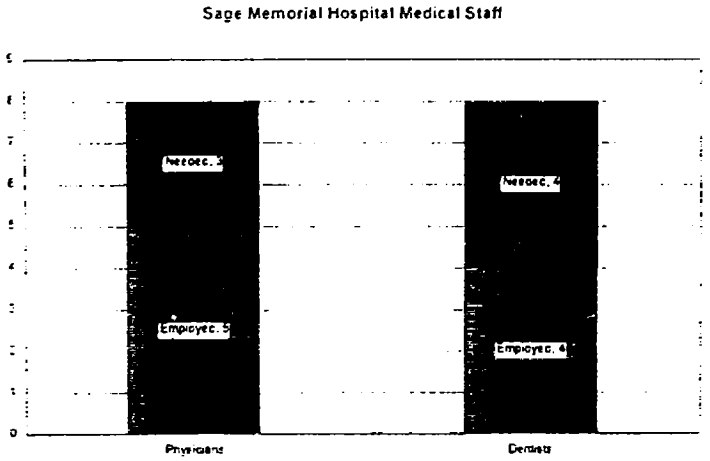


NAVAJO HEALTH FOUNDATION
SAGE MEMORIAL HOSPITAL

FURTHER INFORMATION ABOUT 2003 LEGISLATIVE INITIATIVES

Support for Recruitment and Waivers

Sage can't recruit licensed physicians or dentists to serve its patients. It has 7 positions unfilled. Its dentists estimate that 75% of potential patients don't receive timely care.



Sage is asking for licensing waivers similar to those granted Indian Health Service Hospital. Specifically, this waiver would facilitate the recruitment and licensing of professionals.

Financial Relief for Professional Liability Insurance

Sage's clinical services are excellent with minimal losses. In Calendar 2003, Sage is facing an unbudgeted 150% ($180,000) premium increase. This increase could lead to reduction of services which, in turn, will cause patients to travel 45-60 miles to receive the care.

Sage is asking the State of Arizona to grant liability insurance subsidies to allow Sage to continue its present services and to meet its mission.

Enhanced AHCCCS Reimbursement

Sage's fully allocated costs exceed its fees. AHCCCS reimbursement doesn't cover Sage's costs and, as shown in the payer graph above, Sage doesn't have private insurers whose payments off-sets AHCCCS' low reimbursement.

Sage is asking the State of Arizona to enhance its reimbursement of in-patient and out-patients services for Sage and other small, rural hospitals.

State Pricing for Pharmaceuticals and Other Products

The State of Arizona has negotiated purchasing prices for pharmaceutical supplies and other supplies. Because of its size, volume and non-State and non-IHS status, Sage can't achieve similar costs.

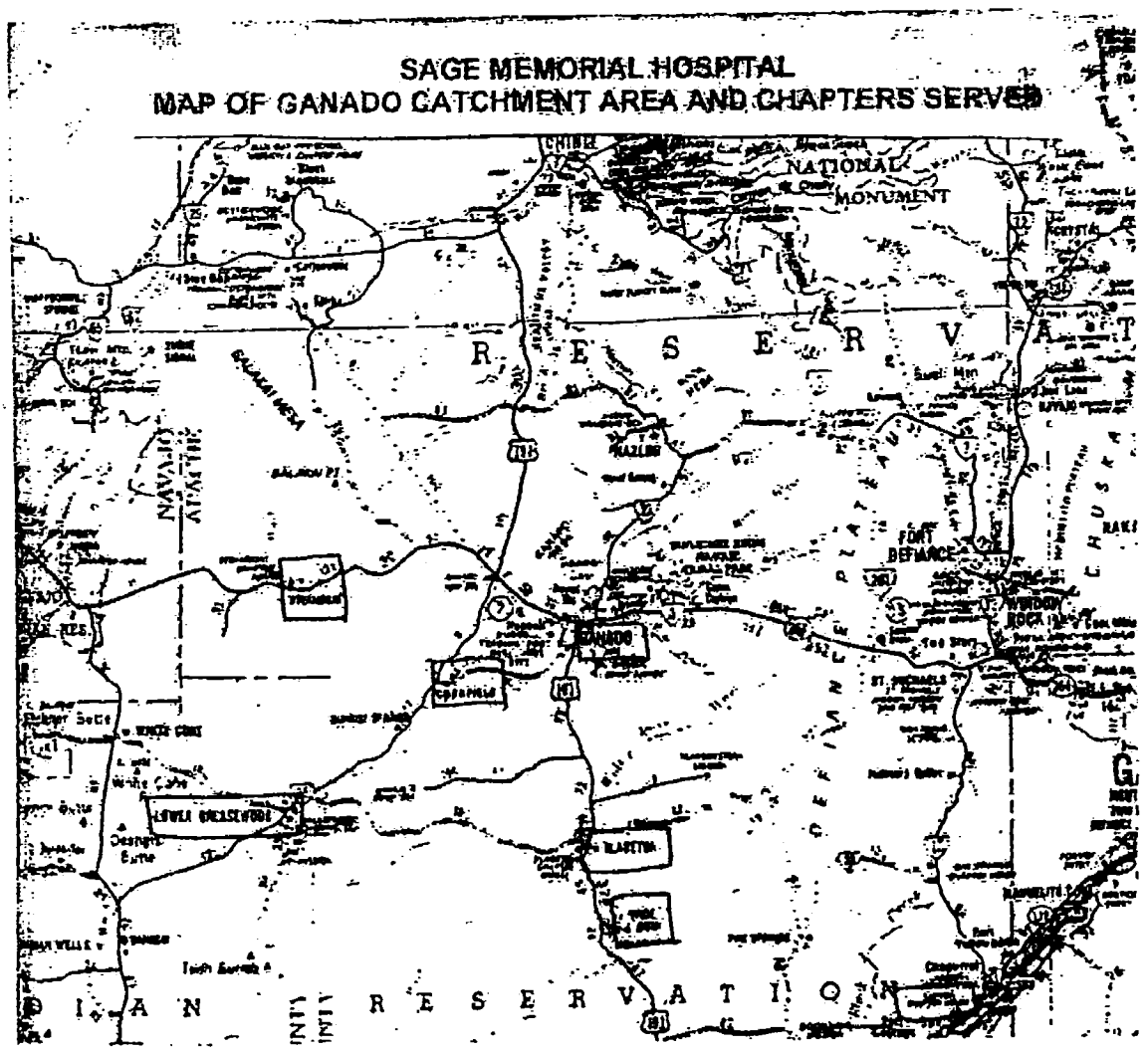
Sage is asking the State of Arizona to grant State contracts and pricing to Sage and other small, rural hospitals.

NAVAJO HEALTH FOUNDATION / SAGE MEMORIAL HOSPITAL

Justification of Need for Two Projects

Navajo Health Foundation / Sage Memorial Hospital ("Sage") is a 100-year old integrated healthcare facility that has a 45-bed hospital, an out-patient facility (Poncel Hall), and other services located on a 100-acre campus. The campus has a 2-lane entrance-exit onto highway 264.

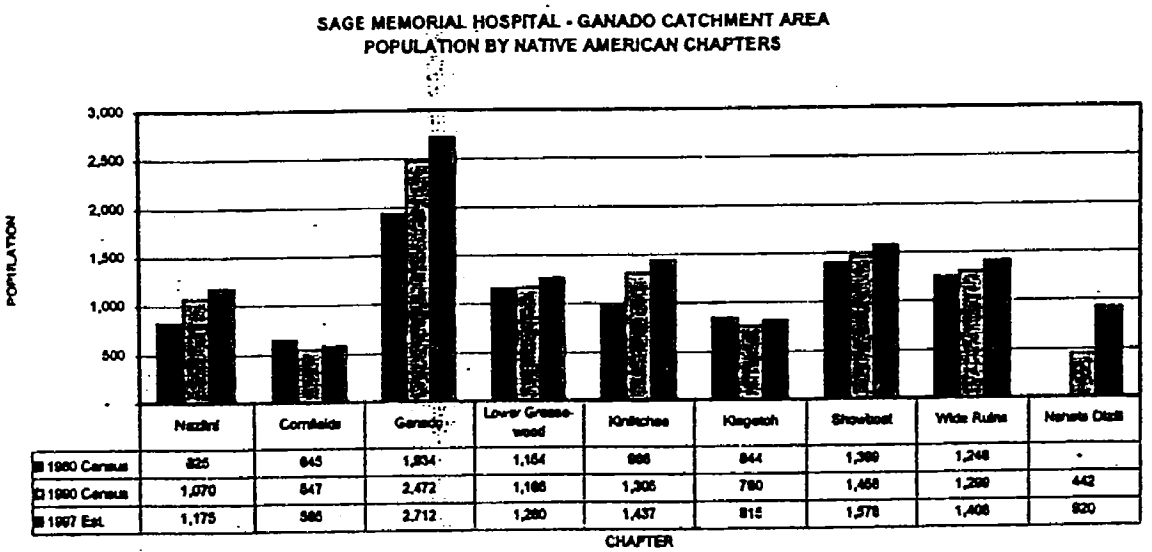
Sage provides primary care medical and dental services to patients residing within a 50-mile radius of Ganado. The Navajo Nation and Indian Health Services have defined the "Ganado catchment area" – an area encompassing over 1,800 square miles. Sage serves the Native American community chapters that are highlighted on the following map. Each chapter's estimated census follows the map.



Chapters that Sage Memorial Hospital Serves

Chapters	Medical Services	Dental Services
Cornfields	Yes	Yes
Ganado	Yes	Yes
Houck	No	Yes
Kinlichee	Yes	Yes
Klagetoh	Yes	Yes
Lower Greasewood	Yes	Yes
Lupton	No	Yes
Newlands/Sanders (Nahata Dziil)	Yes	Yes
Steamboat	Yes	Yes
Wide Ruins	Yes	Yes

According to the "1996 Chapter Images" published in 1997 by the Navajo Nation Division of Community Development (Window Rock, Arizona) the region's population grew from 9,015 (1980) to an estimated 11,888 (1997). The chapters' census information were:



Sage's nine primary care physicians, eight certified physician assistants and five dentists see patients in Poncel Hall:

- Monday through Friday 8 a.m. to 4 p.m.
- Saturday 9 a.m. to 4 p.m.

Sage's 22 medical and dental clinicians had 37,500 patient visits at the Poncel Hall out-patient facility in the twelve months ending September 30, 2001 -- a daily average of 134 patients.

Brad Vargen

1/4/03

Jayne,

The following is the process of getting licensed in Arizona:

1. Pass the two sections of the National written boards (given in yr 2 and year 4 of dental school).

2. Graduate from an accredited dental school with a DDS or DMD degree.

3. Take and pass the Western Regional Examining Board. This is offered at various locations in the U.S. It is monthly in the summer and less often in the winter. This is a clinical exam in which you most show proficiency in 3 clinical restorative procedures and periodontal procedures. Included is the diagnostic (and a lot of subjective) skill to bring patients to the board (you bring your own patients) that have the right lesions/condition to be approved by the examiners. Many people lose points by having their patients rejected by the examiners. If a patient is rejected, a candidate must then find another patient (means you need a back-up patient) or fail that portion of the exam. By having a patient rejected, many candidates cannot make up the lost points to be successful. If unsuccessful on a board exam, one must wait ~1 month to find out and then apply for the next available board which usually means a delay of 3 months before re-taking the board.

   In practical terms a candidate must pay for transportation, lodging, and meals for 2-4 patients. This is on top of the fee of taking the board and malpractice insurance during the board. The fee to take the Board is $1,250 With the other expenses it can cost upwards of $5000. These exams are taken, for the most part, by new grads with $125,000 in educational debt. Since you can't work to pay down the debt until you pass the board, there is tremendous stress in the whole process.

4. After passing the Western Regional Examining Board, you become eligible for licensure in 11 western states, including Arizona. A candidate then must take and pass the state jurisprudence exam which costs $ 300. Then the dentist must pay for a three year license of $650. Finally one is ready to practice.

The grand total from graduation to practice is ~$5,950. This monetary output, along with the time and stress of taking a board is why we have such trouble recruiting dentists. When you add that most dentists are in private practic and have to sell a practice and home to come to Sage compounds the problem. The next hurdle is the salaries offered at Sage are 50% -70% of private practice (depending on experience). The hours are greater than private practice. The work at Sage is a lot of what would be referred to specialists in an ouside setting. This is especially true for the pediatrics and oral

surgery. And obviously we are isolated. This combination of factors creates a very difficult recruiting situation.

The legislature has approved licensure by credentials, but the rules for implimenting this are not written yet (so in a practical sense licensure by credentials does not exist). The feeling is that it would allow dentists with 5 or more years of experience to get a license if their record is clean. It won't be cheap at $2,000. These criteria will also eliminate a fairly large portion of dentists that are early in their career. And it does not remove the roadblocks of the people that already have an investment in their own private practice/home/family/salary, etc.

NAVAJO HEALTH FOUNDATION

SAGE MEMORIAL HOSPITAL
POST OFFICE BOX 457 / GANADO, ARIZONA 86505 / (520) 755-4500

January 3, 2003

Arizona Board of Osteopathic Examiners in Medicine and Surgery
9535 East Doubletree Ranch Rd
Scottsdale, AZ 85258-5539

Dear Arizona State Board of Osteopathic Examiners:

Subject: Isolated rural hospitals

We, the Navajo Health Foundation, which operates Sage Memorial Hospital in Ganado, Arizona, respectfully request the Board of Medical Examiners to seriously and expeditiously consider our request for a variance from the Board's Regulations regarding the practice of medicine within the State of Arizona.

Sage Memorial Hospital is a small, isolated rural not for profit hospital situated on land owned by the Presbytery of the Grand Canyon. We are completely surrounded by the Navajo Nation, and it is over forty miles to the nearest land that is not part of the reservation. We are the only hospital in the area that is open to all persons regardless of race. All of the surrounding area hospitals are operated by the Indian Health Service (IHS). It is with these hospitals that we compete for medical staff and nurses.

It requires over $500 to apply for a license to practice medicine in the State of Arizona, between fees charged directly by the Board and additional fees required to obtain all the documentation that the Board requires. For new graduates from residency the process takes from three to four months. For physicians with experience, it can take up to six months, even if the physician has no history of any problems.

We are currently desperately short of medical staff. The IHS can use locum tenens physicians as long as the have a valid license in any one of the fifty states, or the District of Columbia. Because of the requirements for obtaining an Arizona license, we have a very difficult time finding temporary physicians.

Therefore, the Navajo Health Foundation requests the Board of Medical Examiners to grant it a variance to the State Regulations, to allow physicians who are duly licensed in another state and who meet all of the other stringent credentialing requirements established by the Medical Staff of Sage Memorial Hospital, to practice in at Sage Memorial Hospital, or its clinics for up to six months.

Respectfully yours,

Ralph P. Eccles, D.O.
Medical Director
Sage Memorial Hospital

California - Medical Injury Compensation Reform Act of 1975

- Crisis looming - greater and frequent recovery in medical injury claims coupled with competition for premium dollars.
- By the end of 1972, insurance carriers were paying claims in excess of $180 for each $100 collected in premiums minus operating costs.
- On January 1, 1975, two major medical liability insurance carriers notified Southern California that coverage would not be renewed. Another insurer increased premiums 380% for Northern California physicians.
- Thousands of CA physicians believed they could not absorb the increases nor pass costs onto patients, physicians began refusing to practice.
- Department of Insurance found that plaintiffs were only receiving 34% of direct compensation for injuries suffered.
- In May of 1975, the Governor called a special session that lead to the passage of the Medical Injury Compensation Reform Act (MICRA)

Comparison of MICRA, HEALTH Act and Arizona Provisions

Malpractice Case Law	**California** – MICRA implemented damage caps, limits on contingency fees, allowed for periodic payments	**HEALTH Act*** – Health Efficient, Accessible, Low Cost, Timely Health Care Act of 2002 passed House of Representatives	**Arizona**
Limits on Damages	Economic - None Noneconomic - $250,000 Punitive - None	Economic – None Noneconomic - $250,000 - Punitive – Must be clear and convincing evidence of malicious intent, exempts FDA approved products	Economic – None Noneconomic – None Punitive – None
Statute of Limitations	Three years after injury or one year after discovery, whichever is first (exception for children)	Three years after injury or one year from discovery (exception for children)	Two years from injury or one year from discovery (exception for children)
Periodic Payments	Authorizes periodic payments for awards exceeding $50,000	Authorizes periodic payments for awards exceeding $50,000	Laws 1989, Chapter 289 allowed for periodic payments ruled unconstitutional
Collateral Source Rules	Permits the introduction of evidence	Permits the introduction of evidence	Permits the introduction of evidence
Limits on Contingency Fees	Attorney contingent fees are limited to: 40% for the first $50,000 33.3% of the next $50,000 25% of the next $500,000 15% of all awards over $600,000	Requires court to supervise payment-of-damage arrangement, limiting contingency fees	Upon request, court may review reasonableness of each party's attorney fees

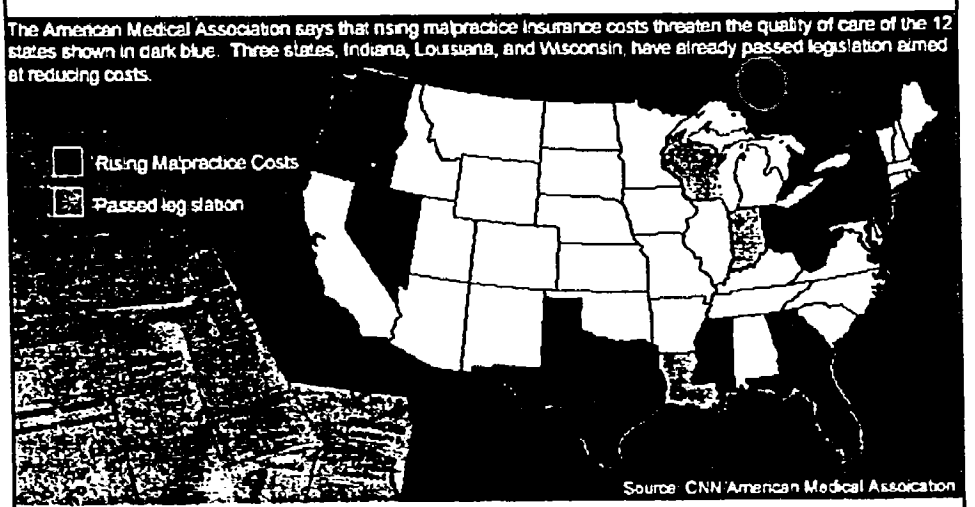
* *Preempts State laws unless such law imposes greater protections for health providers and organizations from liability, loss or damages. Does not preempt statutory limits on punitive damages*

Sources Used – National Conference of State Legislatures, Library of Congress

Rural Physician Study Committee

Tuesday January 7

$180 Billion: Annual cost of the U.S. tort system



$21 Billion: Annual medical malpractice portion

The Cost

- Of the $21 Billion:
  - 22% or $4.62 Billion represents non-economic damage awards
  - 20% or 4.4 Billion represents economic damage awards
  - 17% or $3.57 Billion represents claimant's attorney fees

Tillinghast-Towers Perrin, February 2002

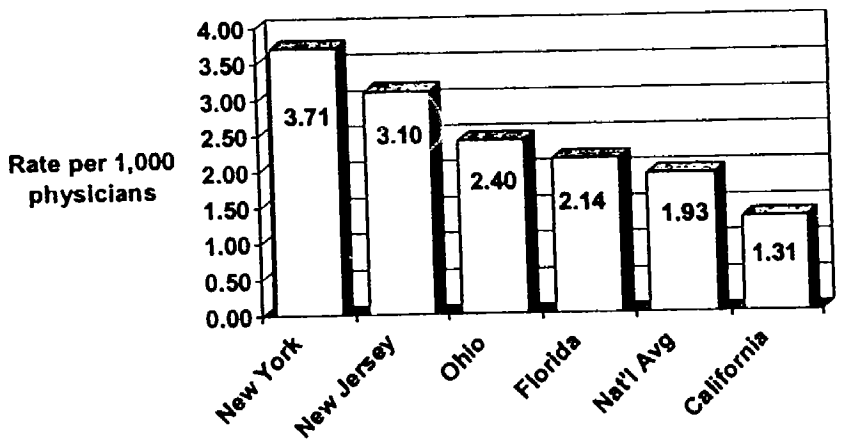
Basic Principles

- Insurance is shared risk . . . It does not create money, it redistributes it
- Insurance is regulated by the state
- Insurance requires capital in excess of premiums to ensure its ability to pay – "surplus"
- As frequency declines volatility increases
- Multi-Line companies (and reinsurers!) have options . . . and the market driven need to generate an acceptable return on investment
- Investors try to maximize high yield *and* safety

Facts

- The amount paid in indemnity and expense is rising dramatically
- Settlement values follow jury verdict values
- Investment Income is down and subsidization of losses has disappeared *almost* completely
- Capital has decreased
- Fewer companies are available to insure physicians, hospitals and health related entities
- Fewer companies have the financial capacity to write new business
- More companies are being downgraded by rating agencies – an issue of security of coverage

Rate of $1 million & greater verdicts per 1,000 physicians



National average minus California

Source: A.M. Best

Fact

- Brain damaged infants are the most frequent and the most expensive claim, accounting for over $2 Billion in payments over the past decade and a half.

PIAA Claims data

Immediate Consequences

- Higher premiums reflect the true cost of losses
  - Under priced coverage no longer available
  - Losses by specialty and geographic location taken into consideration
- Non-renewal and declination of coverage is increasing – sending physicians to the surplus lines market with its more flexible (and higher) pricing
- Hospitals with higher limits particularly hard hit

Additional Issues

- Declining federal and health plan funding
- Increasing unfunded federal mandates and illegal immigration:
  - aggravating uncompensated care concerns
  - aggravating communication and culture problems
- Restrictive regulations
- Increased litigation risk to health insurers
- Aging population demanding brand name prescription drugs and state-of-the-art diagnostic equipment
- Frustration, anger and resignation

The end results . . .

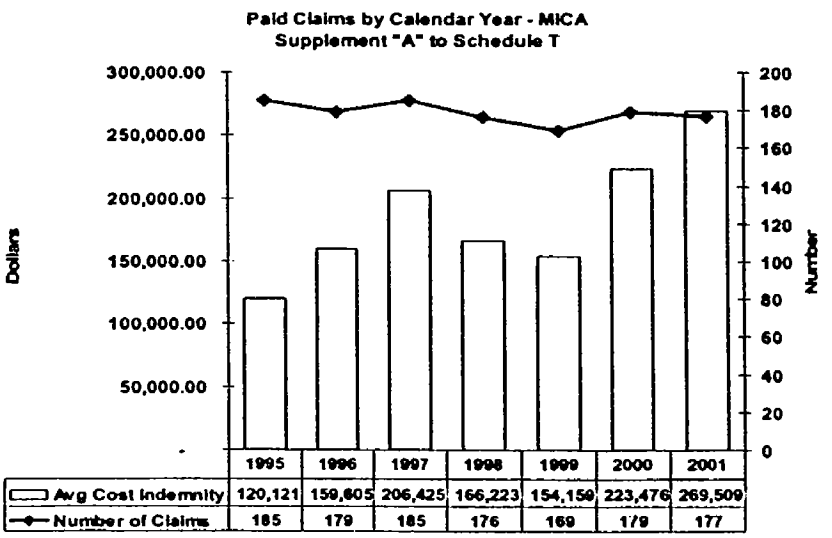
- Reduced high exposure hospital services – particularly Obstetrics & trauma centers
- Fewer physicians – retirement, relocation, alternative careers
- Limitation of physician services – no OB / no surgery / no nursing home patients
- Defensive medicine costs & complications
- Equipment purchases deferred or eliminated

Public Policy questions belong in the Legislature, not the Judiciary

Is it more important to have needed medical care available throughout the state, or . . .

- to have the potential for unlimited recovery if injured?
- to allow claims to be brought many years after an alleged injury?
- to be able to collect twice for the same injury?
- to permit claims under the Vulnerable Adult Act against physicians for medical care?

MICA Results



In Arizona with MICA

The annual premium for $1/3 limits for a

- A family practitioner with
  - . . . no surgery - $12,752
  - . . . minor surgery - $20,050
  - . . . uncomplicated OB - $27,347
  - . . . major surgery - $32,959
- Internist - $12,752
- Obstetrician - $50,361
- General Surgeon - $38,571

National Averages

The average percent increase in the twelve month 2001-2002 period for $1/3 limits

- Internist - 145%
- Obstetrician - 113%
- General Surgeon - 143%

- The average premium nationally July 2002
  - Internist - $12,177
  - Obstetrician - $56,546
  - General Surgeon - $36,354

Where Physicians Pay the Highest Rates

	Internists	General Surgeons	Ob/Gyn
Florida - Dade	56,153	174,268	210,576
Michigan - Detroit	45,761	107,139	140,917
Illinois - Cook	31,722	75,630	110,091
Texas - Valley	26,334	71,200	97,830
Nevada - Clark	23,628	85,056	141,760
Ohio - Cleveland	22,592	74,554	152,496
New York - Nassau/Suffolk	21,648	65,870	115,431

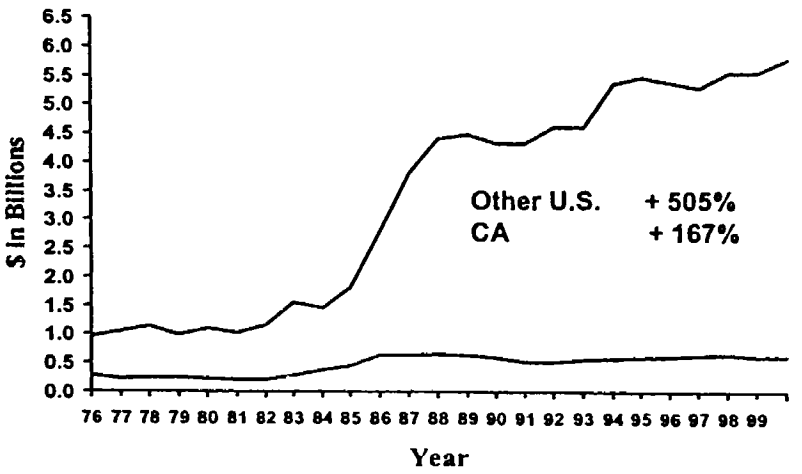
Medical Liability Monitor Oct 2002

One Measure of the Impact of Caps

- Nineteen states have caps ranging from $200,000 to $1,000,000.
  - For internists: only Michigan has rates higher than the national average. In states with non-economic damage caps premiums range from $4,023 to $10,098
  - For general surgeons: only Michigan, Missouri and Utah have rates higher than the national average. In states with non-economic damage caps premiums range from $10,896 to $35,915.
  - For Ob/Gyn: only Michigan, Massachusetts and Maryland have rates higher than the national average. In states with non-economic damage caps premiums range from $17,786 to $55,084

Savings from MICRA Reforms

California vs. U.S. Premiums 1976 - 2000



Arizona's choices

- In Arizona, the cost of professional liability insurance is directly proportional to claims severity and frequency
- The ability of physicians, hospitals and other healthcare entities to pass on cost increases is limited
- Options:
  - Do nothing and let the market and the courts seek a balance, or for the federal government to step in
  - Rationalize the process and the boundaries of available recovery
  - Subsidize the cost with state funds
  - Convert to a new system

Comparison of provisions of 3 new state laws (Ohio has not yet been signed by the Governor)

HCLA/MICRA	Nevada	Mississippi	Ohio
$250,000 Cap on Non-economic Damages (per occurrence)	Non-economic Damages Capped at $350,000 per plaintiff and per defendant. This does not apply to "gross malpractice" or if the court finds exceptional circumstances.	No cap on non-economic damages if judge determines that punitive damages MAY apply. No cap on non-economic damages for disfigurement. Otherwise, non-economic damages capped at: $500,000 now - 7/1/2011 $750,000 7/1/11 - 7/1/17 $1,000,000 7/1/17 →	Cap of $350,000 per plaintiff or $500,000 per occurrence (provided that 3 times economic losses exceeds $250,000.) Cap of $500,000 per plaintiff or $1,000,000 per occurrence if there is permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system or permanent physical functional injury.
Collateral Source Introduction at trial	Mandatory collateral source offsets (excluding amounts for which there is a right of subrogation, if notice is served before settlement or entry of judgment).	None	Collateral Source Introduction at trial, except if the source has a right of subrogation.
Periodic payment of future damages over $50,000 - Mandatory	Set by court at the request of claimant.	None	Periodic payment of future damages over $50,000 - Discretionary
Statute of limitations and statute of repose. 3 years from the date of injury and 1 year from the date of discovery. Exception for minors, the longer of 3 years or age eight.	Prior to October 1, 2002, 4 years from date of injury and 2 years from date of discovery. After October 1, 2002, 3 years from date of injury and 2 years from date of discovery. [EXCEPTION for minors]	For claims "accruing" on or prior to June 30, 1998, 2 years from discovery. For claims accruing after June 30, 1998, 2 years from discovery and 7 years from occurrence. [EXCEPTIONS for minors and foreign objects]	1 year statute of limitations (exceptions) and 4 year statute of repose (exceptions)
Several liability (only) for non-economic damages	Several liability (only) for non-economic damages.	Several liability (only) for non-economic damages. For economic damages several (only) if defendant's fault determined to be 30% or less. If more than 30% at fault,	Old Law: Several liability (only) for non-economic damages

		liability is joint and several to allow defendant to recover 50% of recoverable damages.	
Contingency fee limits	NONE	NONE	NONE
Arbitration – Allowing health care providers and their patients to contract for the arbitration of disputes.	NONE	NONE	Non-binding, non-admissible arbitration allowed. Contractual binding arbitration between the provider and patient prior to care permitted.
	Other: - Volunteer immunity - Limits of $50,000 on all civil damages for governmental entities. - Requires affidavit by a medical expert supporting the allegations. - Mandatory settlement conferences.	Other: - Volunteer immunity - Forum shopping restrictions. - Requirement to file written notice of intention to begin action (60 Days). - Requirement that attorney certify that 1) he has consulted with an expert (i.d. is not required) in the standard of care or negligence; or, 2) the attorney didn't have time to comply with #1; or, 3) Three different experts refused to provide such consultation.	Other: - Sec.2303.23 (Data Collection provisions) - Sec. 2305.234 (Volunteer provider immunity) - Sec. 2323.42 (Pretrial hearing to establish good faith of a claim) - Sec. 4 Creates the Ohio Medical Malpractice Commission - Sec. 5 Superintendent of Insurance shall study the feasibility of a patient compensation fund

MARSHA ARZBERGER
DISTRICT 8

STATE SENATOR
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Arizona State Senate

COMMITTEES:

COMMERCE, VICE CHAIR
APPROPRIATIONS
NATURAL RESOURCES
AND ENVIRONMENT

JOINT LEGISLATIVE BUDGET
COMMITTEE

October 30, 2002

The Honorable John McCain
United States Senate
2400 E. Arizona Biltmore Circle, Ste. 1150
Phoenix, Arizona 85016

Dear Senator McCain:

Thank you for the opportunity to meet with you to discuss problems in health care in rural areas of Arizona. I am chairing or co-chairing two legislative committees on health care issues, the Ad Hoc Study Committee on Retirees Health Benefits (chairwoman) and the Rural Physicians Study Committee (co-chairwoman with Representative Ed Poelstra).

In rural areas in Arizona, hospitals are closing because they financially cannot stay in business; rural physicians are leaving because malpractice insurance premiums have tripled. In Cochise County, a large county in southeastern Arizona, there is only one hospital that still delivers babies, in Sierra Vista. Pregnant mothers do not receive adequate prenatal care because many physicians are not longer practicing obstetrics, and many rural physicians are leaving the rural areas. Pregnant mothers due to deliver have to be transported two hours to Tucson or Sierra Vista for delivery. Some babies don't wait that long and are delivered enroute. This is an unacceptable situation.

For seniors, we have thousands of elderly people living in rural areas where there is no Senior Medicare-HMOs. With no prescription coverage in Medicare Part A or B, many seniors are choosing between paying for their prescription drugs or buying food. We desperately need some federal assistance, through the Medicare program, for elderly people with limited incomes who cannot afford their prescription drugs.

There are some changes that could be made in federal policies that would help to alleviate these critical health care problems in rural areas. I respectfully request that you consider the following actions.

- Raise Medicare reimbursements to rural hospitals and physicians or, in other words, eliminate the present discrepancy in payment rates. Currently, urban areas receive a higher reimbursement rate than rural areas. This does not seem fair or logical.

- Oppose the scheduled formula reductions in Medicare reimbursement rates for hospital and physician services. This anticipated reduction is causing physicians to no longer accept Medicare patients, and further reduces access to health care, especially in rural areas.

- To address the escalating cost of malpractice insurance, the legislative study committee that I co-chair is looking at possible state statute changes to put limits on various types of malpractice awards. Because in Arizona this type of legislation may require a constitutional amendment, the committee is proceeding slowly to study options.

- Please consider another option. At present, Medicaid (AHCCCS in Arizona) patients, indigent patients, and illegal alien patients are required by federal law to be treated in hospital emergency rooms. If hospitals and physicians were protected under federal liability laws for the treatment of these patients, similar to the way Community Health Centers are protected by federal liability laws, costs for malpractice liability insurance could be reduced. I would appreciate your serious consideration of this suggestion.

Sincerely,

Marsha Arzberger
State Senator

MA/bja

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(202) 224-4521

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December 2, 2002

The Honorable Marsha Arzberger
Arizona State Senate
1700 West Washington
Phoenix, AZ 85007

Dear Senator Arzberger:

Thank you for contacting me regarding a number of important health-care matters. I appreciate hearing from you, and I value your input.

First, I agree with you that Congress needs to pass a prescription-drug benefit for seniors. Earlier this year, I supported a "tripartisan" proposal to provide such a benefit. Unfortunately, neither this measure, nor any alternative, was able to garner enough votes to overcome procedural hurdles, and the initiative died with the adjournment of the Congress last month. I will continue to work for passage of a prescription-drug benefit again next year.

With regard to reimbursements, I have joined several of my Senate colleagues in introducing S. 3018, a comprehensive Medicare package that would have addressed the Medicare-reimbursement issues that you refer to in your letter. In total, this bill would provide $43 billion over 10 years to ensure that providers receive adequate reimbursement, and that beneficiaries continue to receive promised benefits.

In particular, you recommend that Medicare reimbursements to rural and urban hospitals be equalized. S. 3018 would help do that, providing $13 billion over 10 years in special rural health-care payments to begin to close the gap between urban and rural payments.

The bill would also increase physician payments over the next three years. It would direct the Medicare Payment Advisory Commission (MedPac) to study the issue and come up with an accurate reimbursement formula that would provide a long-term fix for physician payments.

To address the cost of treating illegal immigrants, I introduced another bill, S. 3013, which would authorize appropriations of $200 million through 2007 for the reimbursement of states and health-care providers for emergency health services furnished to undocumented aliens.

You also make an interesting suggestion about applying federal liability laws to hospitals and physicians with respect to the care they deliver to Medicaid (AHCCCS) patients, indigent patients, and undocumented aliens. This would be similar to the way Community Health Centers are protected. I will give this matter serious thought.

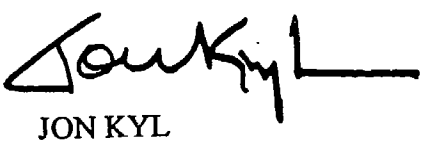
In the meantime, I wanted to make you aware of a medical malpractice measure that I introduced with Senator Mitch McConnell of Kentucky. That measure is S. 1370, the Common Sense Medical Malpractice Reform Act.

Under the McConnell-Kyl bill, a medical malpractice suit would have to be filed within two years (with some exceptions) from the date of the occurrence of the injury, and non-economic damages would be limited to $250,000. Further, punitive damages could be awarded only upon "clear and convincing" evidence that the defendant intended to injure the claimant for a reason unrelated to the provision of health-care services, and that the defendant understood the claimant was substantially certain to suffer unnecessary injury and deliberately failed to avoid it.

This bill would also: establish rules regarding periodic payments in cases of judgments of $100,000 or more; provide liability reform (the liability of each defendant for non-economic and punitive damages is individual only, and not joint); require offsets for damages paid by a collateral source; and cap attorneys' fees (limited to 25 percent of any judgment or settlement recovered).

Please continue to let me know about ways that we might be able to work together on important issues that affect Arizona.

Sincerely,



JON KYL
United States Senator

JK:ts

Research

ARIZONA STATE LEGISLATURE

RURAL PHYSICIANS STUDY COMMITTEE

Minutes of the Meeting
Tuesday, December 2, 2003
9:00 a.m., Senate Hearing Room 1

Members Present:
Senator Marsha Arzberger, Cochair
Chris Cronberg
Alison Hughes
Representative Phil Hanson, Cochair
Representative Armanda Aguirre
Dr. Jim Carland

Members Absent:
Dr. Brian Grogan

Members Excused:
Senator Tim Bee

Staff:
Julie Keane, Senate Health Committee Analyst
Elizabeth Baskett, House of Representatives Health Committee Analyst

Chairman Arzberger called the meeting to order at 9:08 a.m. and attendance was noted. She announced that since the last meeting, Representative Hanson was named co-chair and Representative Aguirre replaced Senator Cannell (previously Representative Cannell).

Review of Last Session's Medical Malpractice Legislation

Julie Keane, Senate Health Committee Analyst, explained that four bills relating to medical malpractice were introduced last session. She noted that of those bills, only SB 1010 was enacted into law, and she explained the provisions. She also explained the provisions of the three bills that were held.

Senator Arzberger stated there was also a federal bill she was monitoring that would have limited certain types of malpractice awards; however, at this late date in the Congressional session the bill is dead.

Update on California's Model for Malpractice Reform

Pete Wertheim, House of Representatives Policy Advisor to the Majority Party, provided an overview of California's malpractice reform as well as an update on malpractice activities in other states. He indicated that in California the Medical Injury Compensation Reform Act of 1975 (MICRA) was the result of a crisis that occurred when physicians went on strike. He noted that MICRA today is considered a national model by many organizations as a good way to reform malpractice laws, and he cited

some of the basic provisions of MICRA. Mr. Wertheim distributed a chart compiled by the National Association of Insurance Commissioners using United States census data and consumer price index (CPI) calculator on malpractice premiums compared by states (Attachment A). He commented on the statistical analysis contained in the handout. He noted that the states of Nevada and Florida recently encountered a serious malpractice crisis situation with insurance premiums, and that information was also highlighted in the handout. Mr. Wertheim stated that the goal to keep in mind is to look at MICRA as the model, which includes the $250,000 cap on non-economic damages.

In response to Senator Arzberger, Dr. Carland explained the situation that occurred in Nevada with the malpractice awards.

Senator Arzberger asked staff whether any information was available to determine whether Arizona is encountering similar problems as occurred in California and Nevada. Mr. Wertheim responded that he has a chart that showed the states in a serious crisis, and Arizona is listed in one of those categories. He said he would locate the chart and forward it to the Committee.

Senator Arzberger commented that she continues to receive calls from the Medical Practitioner Association, which continues to lose specialists due to the high cost of malpractice insurance.

In response to Ms. Hughes, Dr. Carland indicated that the states that have experienced a crisis did not make any constitutional changes in order to put caps on the awards. He commented on an article that appeared recently in the Sunday *Arizona Republic* regarding State and county government liability claims awarded between 1998 and 2002. He emphasized that the "driver" of high malpractice insurance is the payout of the awards, and that is the issue to address.

Mr. Wertheim provided additional examples of his findings of recent reform activity in other states. He noted that legislatures in 34 states for the 2003 session considered measures to change existing systems, and of those, 11 were able to enact laws to varying degrees concerning liability for damages. He said 37 states currently have a cap on damages. He said he would forward updated chart information to the Committee showing the other states and malpractice liability laws as soon as that information is available from the National Conference of State Legislatures (NCSL) and other sources.

Representative Aguirre asked whether there are any studies or recommendations from the American Medical Association (AMA) regarding this issue. Mr. Wertheim responded various groups have had recommendations or proposals; however, the challenge is whether to exert energies on attempting to make changes because of the Constitution prohibition.

Review of Arizona Constitution Relating to Damages
Presentation of Texas Initiative

Ms. Keane stated she would combine the next two presentations and said over 37 states have enacted laws that place caps on damages in medical liability actions. She noted that there are many variances in those 37 states, and she provided some examples. She indicated four states have constitutions that specifically prohibit caps on damages recoverable in medical malpractice actions, and Arizona is one of the four states.

Ms. Keane explained the Texas initiative that placed a cap on damages, which was approved by Texas voters.

Ms. Keane explained that if this Committee recommends limiting damages, a ballot measure would be required to remove the Constitution's prohibition against caps on damages. She said the most recent initiative that was placed on the ballot to amend the Arizona Constitution on this issue was Proposition 103 in 1994, which was rejected by the voters 61 to 39 percent (Attachment B).

Senator Arzberger asked whether there is any statistical information available that indicates the enacting of caps has resulted in lower malpractice insurance premiums in other states. Mr. Wertheim responded there are many studies that have been conducted, and many factors are included in those studies. He noted that generally a majority of the health care profession agrees that capping damages is probably the most effective way to keep rates down. Dr. Carland commented that Colorado has tort reform similar to California, and Colorado's insurance premiums are approximately two-thirds of those in Arizona. He said other states have had caps for a very long time and have had similar experiences. He said one of the problems of the studies is that states that enacted caps within the past two years would not be reflected in the study results.

In response to Representative Aguirre, Mr. Wertheim stated that although many cap provisions in other states are similar, there are also many variations. He referred to Dr. Carland's comments and pointed out that it is difficult to determine the impact of caps over a short period of time. He noted that those states that have had reforms over a longer period of time would produce better data.

Public Testimony

Don Isaacson, Arizona Association of Homes and Housing for the Aging (Association), stated that the Association is a membership of non-profit charitable facilities that provides housing and health care for senior citizens in Arizona. He explained that over twenty years ago in Arizona the Legislature enacted sweeping legislation to deter abuse of the elderly. He noted the changes occurred in the areas of licensing, criminal, and in extra civil liability for facilities above and beyond all other tort liability. He said the situation in recent years has grown from a problem to a crisis, which is reflected in the insurance premiums. He indicated that every facility in the Association's membership has experienced a 400% to 500% increase in liability

coverage over the last several years. He said it threatens the viability of those facilities to provide care, and the situation also diverts resources.

Mr. Isaacson commented that two years ago the Arizona Department of Insurance (DOI) conducted a task force and looked at two problem areas. He said the two areas were homebuilders' liability and nursing home liability. At the end of a six-month evaluation, it was concluded that at least part of the nursing home liability problem related to the tort environment. He said that last year DOI followed up with a survey of casualty carriers to determine who was writing insurance and the circumstances. He said last year when this issue was being discussed at the Legislature, he met with defense counsel to try to find out the problem. He said there are three specific areas in current law in which reform is suggested.

- The definition of elder abuse and neglect.
- Issue of punitive damages.
  Attorney fees.

Representative Hanson commented that legislation was passed last session that protects medical directors and others within a nursing home atmosphere. Mr. Isaacson responded that is correct, and that effort was based on a court decision that found a lawsuit could be brought simultaneously under both medical malpractice and elder abuse. He said another issue arose regarding the statute of limitations, and last year the Legislature brought that issue into conformity.

Mr. Isaacson emphasized that the Association does not want any less protection or punishment in this area. He said they are willing to impose more criminal penalties, more licensing penalties, and more Attorney General oversight in this area; however, the situation today is an environment that is detrimental and needs reform.

Barry Gold, Executive Director, Governor's Advisory Council on Aging, discussed the elder abuse statute and general medical malpractice liability. He said problems have occurred with the elder abuse statute primarily during the past few years. He pointed out that other insurance premiums continue to rise dramatically and it is not because of the elder abuse statute. He said there are methods to deal with this situation that are not being brought to the table. He noted that the suggested penalties may appear to be a solution; however, they are very difficult to implement. Mr. Gold commented that civil resolution is sometimes the only practical method that vulnerable frail adults have to seek justice. He said criminal cases are very difficult to prove. He noted that when the elder abuse statute passed twenty years ago, it was a way to help the population that needed extra protection.

Mr. Gold commented on some of the changes that have been suggested such as in the areas of negligence, neglect, increasing criminal prosecution, and punitive damages. He noted that one item not mentioned relates to what has occurred in other states, such as Minnesota and New Mexico. Those states have medical review teams that have helped control the cost of liability insurance. He said there may have been medical review teams in Arizona in the 1980s, but he is not sure how effectiv they may have been. He noted that perhaps that issue needs to be revisited. He said the other issue

deals with the insurance companies and the rising rates. He commented that he attends many meetings that include representatives of the nursing home industry and physician groups, but the insurance industry is not present at those meetings. Mr. Gold believes the insurance industry should be included in the meaningful discussions. In summation, Mr. Gold said that the medical liability issue is a problem, nursing homes are having difficulties, and medical directors are resigning. He emphasized the need for providing a high level of quality of care for both physicians and the elderly.

Representative Hanson commented on a personal experience with nursing homes, and said he is concerned about protecting physicians and nursing homes from large claims for situations that are mistakes and not long-term abuse or neglect. He said an individual's life savings could be decimated by the costs associated with nursing homes and part of those costs are related to the high insurance rates paid by nursing homes to remain in business.

Mr. Gold agreed that high insurance rates are causing difficulties in nursing homes. He said nursing homes provide a high level of care and are a necessary part of our State. He indicated that all cases required to be filed are included in the Elder Abuse Registry at the Arizona Attorney General's Office. He said those cases are reviewed on an ongoing basis, but it is important to distinguish between simple mistakes and an egregious act. He commented that many changes are occurring in nursing homes to maintain quality of care.

Adopt Recommendations

Senator Arzberger stated that this Committee ends on December 31, 2003. A list of Proposed Recommendations Options was distributed (Attachment C). Discussion took place on whether a recommendation should be made that a new Study Committee be appointed through legislation. She pointed out that the work should continue with a focus on malpractice insurance in current statutes or possibly broadened to a discussion of health care critical issues for physicians, hospitals and nursing homes.

Ms. Hughes commented that there is another committee on rural health chaired by Senator Cannell, and she wondered whether that committee could be overlapping with a broadened purpose of this Committee. Ms. Keane responded that the committee referenced is the Statewide Health Care System Task Force, which has been extended to 2004. Senator Arzberger said Ms. Hughes raises a good point, and she asked the members for their suggestions.

Senator Cannell stated there is a group working on the malpractice issue that will create legislation for next session. He commented that at a recent meeting of the NCSL in Denver, two priorities were established. He noted that a committee would probably be formed on quality and cost of health care. In addition, he said he was given a charge to put something together regarding the rural infrastructure and access to care in rural areas. He indicated there would be a focus on health care professionals in rural areas and how to attract and retain them in those areas. He emphasized the importance of continuing this Committee, and believes it is very valuable as a public forum. Senator Arzberger said she agrees that the public forum aspect should continue on this issue.

Representative Hanson moved that the Rural Physician Study Committe adopt the following recommendation:

(a) to continue the Study Committee with a new charge to monitor the multiple and complex issues affecting the delivery of medical care in this State that focuses on professional malpractice liability on access to care and quality of care and on critical issues relating to physicians, hospitals and nursing homes. The motion CARRIED by voice vote.

Representative Hanson moved that the Rural Physician Study Committee adopt the following recommendation as amended:

(b) to work collaboratively with stakeholders to develop strategies that meet the goals of ensuring the availability of qualified healthcare personnel at all levels of the health care system, enhancing quality medical care, adequately compensating those injured by negligent medical care while ensuring balanc in assessing medical negligence, and promoting the availability of (and viability of the companies providing) liability insurance to qualified medical practitioners. The motion CARRIED by voice vote.

Representative Hanson moved that the Rural Physician Study Committee adopt the following recommendation:

(c) to request that a standing committee of the House of Representatives and/or Senate such as Insurance/Finance investigate the possibility of placing limits on malpractice suits; thus encouraging physicians to continue t maintain their practices in rural communities. The motion CARRIED by voic vote.

Senator Arzberger stated that staff would issue a report soon, which will include all meeting minutes and handouts. She thanked everyone for their participation on this Committee and said she looks forward to further work on this issue.

There being no further business, the meeting was adjourned at 10:47 a.m.

Respectfully submitted,

Nancy DeMichele
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

Agendas can be obtained via the Internet at http://www.azleg.state.az.us/iagenda/iagenda.htm

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

RURAL PHYSICIAN STUDY COMMITTEE

Date: Tuesday, December 2, 2003

Time: 9 to 11 a.m.

Place: Senate Hearing Room 1

AGENDA

1. Call to Order
2. Review of Last Session's Medical Malpractice Legislation – Staff
3. Update on California's Model for Malpractice Reform – Staff
4. Update on Other State's Medical Malpractice Reform – Staff
5. Review of Arizona Constitution Relating to Damages – Staff
6. Presentation of Texas Initiative – Staff
7. Adopt Recommendations
8. Committee Discussion
9. Public Testimony
10. Adjourn

Members:

Senator Marsha Arzberger, Cochair
Senator Tim Bee
Mr. Jim Carland
Dr. Brian Grogan - NG

Representative Phil Hanson, Cochair
Representative Amanda Aguirre
Mr. Chris Cronberg
Ms. Alison Hughes

JK/cd

Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602)542-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

California - Medical Injury Compensation Reform Act of 1975 (MICRA)

- Crisis looming - greater and frequent recovery in medical injury claims coupled with competition for premium dollars.
- By the end of 1972, insurance carriers were paying claims in excess of $180 for each $100 collected in premiums minus operating costs.
- On January 1, 1975, two major medical liability insurance carriers notified Southern California that coverage would not be renewed. Another insurer increased premiums 380% for Northern California physicians.
- Thousands of CA physicians believed they could not absorb the increases nor pass costs onto patients, physicians began refusing to practice.
- Department of Insurance found that plaintiffs were only receiving 34% of direct compensation for injuries suffered.
- In May of 1975, the Governor called a special session that lead to the passage of the Medical Injury Compensation Reform Act (MICRA)

Basic Provisions	MICRA California
Limits on Damages	Economic - None Non-Economic - $250,000 Punitive - None
Statute of Limitations	Three years after injury or one year after discovery, whichever is first (exception for children)
Periodic Payments	Authorizes periodic payments for awards exceeding $50,000
Collateral Source Rules	Permits the introduction of evidence, such as health insurance
Advanced Notice of a Claim	Claimant must give a 90-day notice of a claim (extends beyond statute of limitations)
Limits on Contingency Fees	Attorney contingent fees are limited to: 40% for the first $50,000 33.3% of the next $50,000 25% of the next $500,000 15% of all awards over $600,000

Sources Used – National Conference of State Legislatures, Library of Congress

Malpractice Premium Comparison by State
(1976, 1986 and 2000)

Year	California	United States	Florida	Nevada
1976				
total premium	$228,451,000	$1,182,000,000	$18,357,000	$1,978,000
population (1970 census)	19,971,069	203,302,031	6,791,418	488,738
percent of US population	9.8%	100.0%	3.3%	0.2%
percent of US premium	19.3%	100.0%	1.6%	0.2%
premium per person	$11.44	$5.81	$2.70	$4.05
1986				
total premium	$629,448,000	$3,435,000,000	$173,522,000	$3,311,000
population (1980 census)	23,667,764	226,542,199	9,746,961	800,508
percent of US population	10.4%	100.0%	4.3%	0.4%
percent of US premium	18.3%	100.0%	5.1%	0.1%
premium dollars (adjusted for inflation)	$327,312,960	$1,786,200,000	$90,231,440	$1,721,720
percentage change in premium dollars (adjusted for inflation)	43.3%	51.1%	391.5%	-13.0%
premium per person	$26.60	$15.16	$17.80	$4.14
premium per person (adjusted for inflation using CPI calculator)	$13.83	$7.88	$9.26	$2.15
2000				
total premium	$609,712,000	$5,549,552,000	$505,535,000	$508,000,000
population	33,871,648	281,421,906	15,982,378	1,998,259
percent of US population	12.0%	100.0%	5.7%	0.7%
percent of US premium	11.0%	100.0%	9.1%	9.2%
premium dollars adjusted for inflation	$201,204,960	$1,831,352,160	$166,826,550	$167,640,000
percentage change since 1976 in premium dollars adjusted for inflation	-11.9%	54.9%	808.8%	8375.2%
percentage change since 1986 in premium dollars adjusted for inflation	-38.5%	2.5%	84.9%	9636.8%
premium per person	$18.00	$19.72	$31.63	$254.22
premium per person (adjusted for inflation using CPI calculator)	$5.94	$6.51	$10.44	$83.89
Percentage change in premium per person (adjusted for inflation using CPI calculator)	-51.9%	111.9%	386.2%	2072.9%

Sources: NAIC Insurance Company Profitibility Reports 1976 to 2000; U.S. Census Data (1970, 1980 and 2000); Consumer Price Index Calculator, U.S. Dept. of Labor

Medical Malpractice: Tort Reform
Recent States Activity

Legislators in 34 states considered measures to change existing systems during the 2003 session. 11 have enacted laws of varying degrees concerning liability for damages.

Examples of Recent Activity

Arkansas – Amended the requirement for burden of proof. The plaintiff must use expert testimony provided only by a medical care provider of the same specialty as the defendant.

Florida – After six months of negotiations and three special sessions, Florida capped non-economic damages against individual physicians at $500,000, $1 million against multiple physicians, $750,000 against hospitals and $1.5 million against multiple hospitals. Other provisions:

- Caps can be increased for severe malpractice.
- Lower caps for emergency room providers.
- Freezes malpractice premium rates.
- Error reporting and tracking by hospitals and physicians.

Idaho – Reduced cap on non-economic damages from $400,000 to $250,000. Limited judgements for punitive damages not to exceed $250,000 or an amount three times the compensatory damages. Repeals exception for cause of action from the manufacture of any medical device or pharmaceutical products.

Nevada – Requires malpractice insurers to inform the state 120 days before they withdraw. Allows the state to require companies to provide an additional 60 days of coverage in cases where physicians would not have access to other coverage. Prohibits malpractice carriers from increasing premium rates because of investment losses. Requires at least five of six members of the Medical Board to find against a physician.

New York – Altered jury awards in medical malpractice cases to structure payments and the application of inflation factors determined by the jury to remove costly balloon payments in awards. Removed the ability for awards to outlive the patients. Allowed greater payments of non-economic awards over longer period of time.

Texas – Placed a $750,000 cap on non-economic damages; a $250,000 cap against individual providers and hospitals; a $500,000 cap on damages against multiple hospitals and $750,000 cap in cases with multiple defendants. Proposition 12 allows lawmakers to limit damages for a plaintiff's non-economic damages with a three-fifths vote of the Legislature. *The Texas Medical Liability Trust, which insures more than 1/3 of practicing physicians, pledged to reduce liability rates by 12%.*

West Virginia – Enacted a tax credit, which allows an annual credit equal to 21% of a physician's adjusted medical liability premium. Set maximum awards for non-economic damages and allows the presentation of collateral source benefits.

Source -- National Conference of State Legislatures

12/02/03

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

STATE MEDICAL LIABILITY LAWS TABLE

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Alabama	§6.5.482 (1975, 1993) 2 years from date of injury or 6 months from reasonable discovery; no suit may be brought 4 years after date of injury; minors under 4 by age 8 if statute would have otherwise expired by that time	§6.5.544 (1987) $400,000 limit on non-economic damages, including punitive damages; §6.5.547 $1 million limit on total damages (court decision upheld cap only in wrongful death actions); §6-11-21 $250,000 cap on punitive damages except for wrongful death and suits alleging patterns of intentional wrongful conduct, actual malice or defamation[2]	§6.5.545 (1987) Discretionary offset; allows the jury to be informed if medical bills and/or lost wages have been paid by a third party	§6.5.543 (1987) Mandatory periodic payment of future damages in medical injury cases in excess of $150,000		§6.5.548(1997) Expert witness must be certified in same specialty as defendant and must have practiced within previous year		Alabama Supreme Court upheld constitutionality of statute of limitations in *Barlow v. Humana*, (1986); *Tucker v. Nichols* (1983); *Reese v. Fite Memorial Hospital*, (1981); non-economic damages portion of damage awards limitations ruled unconstitutional in *Moore v. Infirmary Assoc.* (1991); cap on total damages, excluding wrongful death, overturned in *Ray v. Anesthesia Assoc.*(1995); punitive damages cap ruled unconstitutional in *Henderson v. Alabama Power Co.* (1993); non-medical malpractice statute similar to collateral source rule struck down in *American Legion Post No. 57 v. Leahey* (1996)
Alaska	§09.10.070 (1962) 2 years from discovery of injury; tolled by disability	§09.17.010 (1997) For injuries after Aug. 7, 1997, non-economic damages cap greater of $400,000 or plaintiff's life expectancy, in years, multiplied by $8,000; for severe injury, the greater of $1 million and life expectancy in years times $25,000; §9.17.020 (1997) punitive damages cap greater of $500,000 or 3 times compensatory damages, whichever is greater, unless malicious action, then greater of $7 million or 4 times compensatory damages; 50% of punitive damages to state fund	§09.55.548 (1992) Mandatory offset of collateral sources, except federal program benefits requiring subrogation and life insurance	§09.55.548 (1976) Discretionary periodic payment of future damages for medical treatment, care or custody, loss of future earnings, or loss of bodily function	§09.55.536 (1976) Mandatory submission of claims to pretrial screening panel, unless court waives this requirement or parties agree to arbitrate; results of screening admissible at later trial	§09.20.185 (1997) Expert witnesses must be licensed and trained in the defendant's discipline and certified by a board recognized by the state		Alaska Supreme Court upheld constitutionality of pretrial screening panels in *Keyes v. Humana Hospital Alaska, Inc.*, (1988)

[1] Expert witness rules commonly established by case history. Summary chart includes only rules established by statute.

[2] Underline indicates statutes overturned by decisions of court (see *Case History* for specific citation) or was repealed by act of the legislature.

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Arizona	§12.502, 542 (1971, 1984) 2 years from injury or death; foreign object or intentional fraud: 1 year from discovery; minor or unsound mind: statute begins upon removal		§12.565 (1976, 1984) Discretionary offset; evidence of collateral sources of payment for economic damages admissible at trial	§12.582 May elect for periodic payments made pursuant to court rule; claim for future damages is effective unless objecting party shows trial or arbitration should not be conducted			§12.568 (1976) Upon request by a party, the court will review the reasonableness for each party's attorney fees	Arizona Supreme Court upheld constitutionality of collateral source rule and mandatory pretrial screening panel requirement in *Eastin v. Broomfield* (1977); periodic payments statute ruled unconstitutional in *Smith v. Myers* (1994)
Arkansas	§16.114.203 (1979, 1991) 2 years from the date of injury; foreign objects: 1 year from discovery; minors: before age 9, until age 11; plaintiff must bring suit within 1 year from date of removal of disability			§16.114.208 (1979) Discretionary periodic payment of damages over $100,000; upon death of claimant, court may deduct future pain and suffering and care expenses		§16.114.207 (1979) Testimony by experts whose compensation depends upon outcome of suit prohibited		
California	Civ. Proc. §340.5 (1975) 3 years after injury or 1 year after discovery, whichever is first; in no even more than 3 years after injury, unless caused by fraud, concealment, or a foreign object; minor under age 6: 3 years or before age 8, whichever is longer; tolled for foreign body cases until reasonable discovery	Civ. §3333.2 (1975) $250,000 limit for non-economic damages	Civ. §3333.1 (1975) Discretionary offset; evidence of collateral sources may be introduced at trial	Civ. Proc. §667.7 (1975) Mandatory periodic payment of future damages award exceeding $50,000, upon request of party; payments to continue after death of plaintiff to parties to whom judgement creditor owed a duty of support			Bus. & Prof. §6146 (1975, 1987) Sliding scale fees may not exceed 40% of the $50,000, 1/3 of the next $50,000, 25% of the next $500,000, and 15% of damages exceeding $600,000	California Supreme Court upheld constitutionality of damage awards limits and collateral source rules in *Fein v. Permanente Medical Group* (1985); periodic payment of damage awards upheld in *American Bank and Trust Co. v. Community Hospital of Los Gates . Saratoga, Inc* (1984); attorney fees statute upheld in *Roa v. Lodi Medical Group, Inc* (1985); additional attorneys' fees provisions rejected by voters in 1996
Colorado	§13.80.102(5) (1988) 2 years from date of accrual; in no event more than 3 years from act; foreign objects: 2 years from discovery; minors under age 6 must bring claim before age 8	§13.21.302 (1988) $1million limit for damages against a hospital or physician; non-economic damages limited to $250,000; court may increase limit in certain situations; §13.21.203 (1989) permissible recovery for wrongful death limited to $250,000; §13.64.302.5(5) (1990) no punitive damages against a physician for adverse outcome of prescription, medically prescribed (1991) or experimental drugs (1991) where FDA protocol was followed; §13-21-102 (1990) punitive damages may not exceed actual damage award; court may increase punitive damages to 3 times in certain situations	§§13.21.111.6 (1986) Mandatory offset for sources not contracted by and paid for by the claimant	§13.64.203 (1988) Mandatory periodic payment of future damage awards exceeding $150,000	§13.22.402; §13.22.311, 401-409 (1988) Mandatory screening for claims of $50,000 or less by "arbitration panel"; findings of panel not admissible at trial; court may require mediation of medical injury claims	§13.64.401 Expert witness must be licensed physician and substantially familiar with standard of care on date of injury; §13.20.602 (1988) claimant must file certificate of review which states that an expert was consulted and is competent to testify		Colorado Supreme Court upheld constitutionality of non-economic damage awards cap in *Scholz v. Metropolitan and Pathologists*

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Connecticut	§52.584 (1969) 2 years from discovery, no more than 3 years after act; §52.555 (1991) wrongful death: 2 years from death; no more than 5 years from disputed act or omission		§52.225a (1985) Mandatory offset; court reduces award by collateral sources of payment received by plaintiff, but credits plaintiff with any premiums paid	§52.225d (1987) Discretionary periodic payment of all damages in excess of $200,000; the parties have 60 days to reach payment terms for damages over $200,000; if no agreement is reached, a lump sum is awarded	§§38a-56, 19f (1977) Voluntary pretrial screening; unanimous findings of panel members admissible at trial	§52.184c(d) (1986) Expert witness must be licensed physician practicing for 5 years before date of injury	§52.251c (1986) Sliding scale fees may not exceed: third of first $300,00; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million	
Delaware	§18.6856 (1976) 2 years from injury; 3 years from discovery if latent injury; minor: age 6 or same as adult	§18.6855 (1976) Punitive damages may be awarded only on finding of malicious intent to injure or will or wanton misconduct	§18.6862 (1976) Discretionary offset; evidence of "public collateral sources of payment" may be introduced (evidence of life insurance or private collateral sources of compensation benefits excluded)	§18.6864 (1976) Discretionary periodic payment of future damages in medical injury actions only; compensation for future pain and suffering and future expenses deducted from balance of payments on death of plaintiff	§18.6801-6814 (1976) submission to review panel on demand; negative opinion admissible as prima facie evidence at any subsequent trial; expert witness testimony may be required for panel	§18.6853-6854 (1976) Required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; experts knowledge of similar locality in order to testify	§18.6865 (1976) Sliding scale fees may not exceed: 35% of first $100,000; 25% of next $100,000; and 10% of damages exceeding $200,000	
District of Columbia	§12.301-2 (1995) 3 years from reasonable discovery; wrongful death: 1 year from death							
Florida	§95.11 (1972, 1980) 2 years from injury or discovery, no more than 4 years from injury; minors: age 8; if fraud, concealment of injury or intentional misrepresentation prevented discovery within 4 year period, 2 year limit from discovery, not to exceed 7 years after the act	§768.73 (1997) Punitive damages in excess of 3 times economic damages or $500,000 presumed excessive; §766.207, 209 (1988) where parties agree to binding arbitration, (1) net economic damages for wage loss including to 80% of wage loss and earning capacity; (2) non-economic damages limited to maximum $250,000 calculated for capacity to enjoy life; where the plaintiff refuses to arbitrate, non-economic damages may not exceed $350,000 plus net economic damages including past and future medical expenses and 80S of wage loss and loss of earning capacity; no limits where defendant refuses to arbitrate	§768.76 (1986) Mandatory offset by court, except for those collateral sources for which there are subrogation rights; §§766.207, 209 (1988) rule extends to binding arbitration cases	§768.78 (1986) Mandatory periodic payment of future damage award exceeding $250,000, at the request of a party; defendant may elect to pay lump sum for future economic losses and expenses reduced to present value; §766.207(7)(c) (1988) damages for future economic losses awarded by arbitration payable on periodic basis under 766.202(8)	§766.106-107 (1985) Court may require submission of claim to an arbitrary panel; result not admissible in a later trial	§766.102(c) (1988) Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed	Atty. Conduct Reg. 4-1.5(f)(40(b) Separate sliding scales for cases settling before filing an answer or appointing an arbitrator, cases settling before or after going to trial, and cases in which liability is admitted and only damages contested; 5 % extra for cases appealed	Voluntary binding arbitration caps found unconstitutional in *Univ. of Miami School of Medicine v. Echarte*; 1975 statute, without the subrogation exception, upheld in *Pinillos v. Cedars of Lebanon Hospital Corp.*(1981) and *Smith v. Department of Insurance* (Fla. 1987); earlier pretrial screening panel provision found unconstitutional in *Aldana v. Holub* (1980)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Georgia	§9.3.71-73, 9.63 (1992) 2 years from injury or death; in no event longer than 5 years from act or death; foreign object: 1 year from discovery; minors: age 7 and, and in no event later than age 10; agreement by parties to arbitrated tolls statute	§51.12.5.1 (1992) $250,000 cap on punitive damages, unless demonstrated intent to harm	§51.12.1 (1987) Collateral sources evidence admissible to jury		§9.9.61-63 (1997) Voluntary arbitration subject to court review; binding if prior agreement to make it so	§9.11.9.1 (1998) Complaint must generally contain an affidavit of an expert stating that the facts justify a claim of negligence		Georgia Supreme Court upheld as constitutional statute of repose in *Craven v. Lowndes County Hospital Authority* (1993); collateral source rule found unconstitutional in *Georgia Power Co. v. Falagan, et al* (1991); *Dentor v. Con-Way Southern Express, Inc* (1991)
Hawaii	§657.7.3, 671.18 (1973, 1986) 2 years from discovery, not to exceed 6 years from act; minors: age 10 or within 6 years, whichever is longer; arbitration tolls statute until 60 days after the panel's decision is delivered but for no more than 18 months	§663.8.5, 8.7 (1986) $375,000 cap for pain and suffering damages; excludes mental anguish, disfigurement, loss of enjoyment of life, and loss of consortium			§601-20 (1986) Mandatory nonbonding arbitration for all cases involving $150,000 or less; §671.11-20 (1976) mandatory submission of medical injury claim to medical claim conciliation panel; results not admissible at trail		§607.15.5 (1986) Attorney fees must be approved by the court	
Idaho	§5.219 (1971) 2 years from injury; foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later	§6.1603 (1987) $400,000 cap on non-economic damages in any tort action, unless personal injury cause by "willful or reckless misconduct" or felony; cap adjusted annually according to the state's adjustment of the average annual wage; §6.1606 (1990) removed 1992 Sunset	§6.1606 (1990) Mandatory offset of collateral sources except for federal benefits, life insurance and subrogation rights	§6.1602 (1987) Discretionary periodic payment of future damage awards exceeding $100,000, excluding cases involving intentional tort, gross negligence, or extreme deviation from standards unless agreed to by claimant	§6.1001-1011 (1976) mandatory submission of claim to hearing panel; results not admissible at trail	§6.1012 (1990); Claimant must prove negligence by direct expert testimony; §6.1013 (1976) Expert witness must have knowledge of community standards		Idaho Supreme Court upheld constitutionality of statute of limitations in *Homes v. IWASA* (1983); earlier damage awards limit applying only to medical liability overturned in *Jones v. State Board of Medicine* (1976) *cert denied* (1977)
Illinois	§735.5/13.212 (1992) 2 years from discovery but not more than 4 years from act; statute tolled for disability (where plaintiff is insane, mentally ill or imprisoned); minors: 8 years after act but not after age 22; §740.180/2 (1995) wrongful death: 2 years from death, if statute of limitation on personal injury still valid at time of death	§735.5/2.1115.1 (1997) $500,000 cap on non-economic damages; §735.5/1115 (1985) punitive damages not recoverable in medical malpractice cases	§735.5/2.1205 (1992) Claimant may apply within 30 days of judgment for 50% reduction of collateral payments for lost wages or disability benefits; 100% of medical benefits (with exceptions), but not more than 50% of total award	§735.5/2.1705-6 (1985) Voluntary or discretionary periodic payment of future damages awards over $250,000		§735.5-8 Plaintiff required to provide affidavit stating that competent expert has been consulted	§110.2.1114 (1985) Sliding scale fees may not exceed third of first $150,000; 25% of next $850,000 and 20% of damages exceeding $1 million; §735.5/2.1114 (1992) attorney may apply to the court for additional compensation under certain circumstances	Illinois Supreme Court upheld constitutionality of statute of limitations in *Anderson v. Wagner* (1979), *reversing Woodward v. Burnham City Hospital* (1987); non-economic damage award cap struck down in *Best v. Tayor Machine Works* (1997); similar 1975 statute overturned in *Wright v. Central Du Page Hospital Association* (1976); pretrial screening panel provision struck down and periodic payment of damage awards upheld in *Bernier v. Burris* (1986)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Indiana	§34-18-7-1 (1998) 2 years from act, omission, or neglect; minors: under age 6 until age 8; applies regardless of minority or other disability	§34-18-18-1 (1998) For acts prior to 1990, $100,00 cap from a single provider and $500,000 cap from all providers and Patient Compensation Fund (PCF); as of 1990, $750,000 cap for all providers and PCF; as of July 1999, $250,000 limit for each provider and a $1,250,000 for all providers and PCF; only 1 recovery per single injury; no damage caps in cases not brought against qualified providers	§34.44.1.2 (1998) Collateral sources except life insurance, insurance payments made directly to plaintiff, plaintiff's family or state/federal benefits paid before trail admissible at trail	§34.18.15.1 (1985) Discretionary periodic payment	§34.18.8.4-6 (1975) mandatory submission of claim, unless parties agree otherwise, of claims more than $15,000; panel determination is admissible at any later trail	§34.18.10.23 Medical review panel's testimony may qualify as expert testimony to establish prima facie	§16.9(5).5.1 (1975) Plaintiff's attorney fees may not exceed 15% of any award that is made from PCF (covers portion of an award that exceeds $100,000)	Indiana Supreme Court upheld constitutionality of statute of limitation, but established an exception where medical condition prevented discovery in *Martin v. Richey* 1999); original 1975 pretrial screening panel, limits on damage awards, and statute of limitation provisions upheld as constitutional in *Johnson v. St. Vincent Hospital* (1980); *St. Anthony Medical v. Smith* (1992); *Bova v. J.H. Roig, M.D* (1992)
Iowa	§614.1(9) (1997) 2 years from reasonable discovery but not more than 6 years from injury unless foreign object; minors under age 8: until age 10 or same as adults, whichever is later; mentally ill: extends to 1 year from removal of disability		§147.136 (1975) Mandatory offset of collateral sources	§668.3 (1987) Discretionary court-ordered periodic payment of future damages	§679A.1 (1981) Written arbitration agreement valid and irrevocable	§147.139 Qualifications of the expert must relate directly to problem at issue	§147.138 (1975) Court may review fees in any personal injury or wrongful death action against specified health care providers or hospitals	Eight Circuit upheld constitutionality of original 1945 statute of limitation in *Fitz v. Dolyak* (1983)
Kansas	§60.513.7(c) (1965) 2 years from act or reasonable discovery by not more than 4 years after injury; incompetent: 1 year from removal, but no more than 8 years from act	§60-19a02 (1988) $250,000 cap on non-economic damages recoverable by each party from all defendants; §60.3702 (1994) punitive damages limited to lesser of defendant's highest gross income for prior 5 years or $5 million; if profitability of misconduct exceeds cap, court may award 1.5 times profit instead; judge determines punitive damage; punitive damages unavailable in wrongful death cases	§60.3801-3807 (1992) Collateral sources admitted where plaintiff claims $150,000 or more in damages		§65.4901 (1976) Voluntary submission to medical screening panel upon request of party; §60.3501-3509 (1987) decisions admissible at any subsequent trial	§60.3412 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice		Kansas Supreme Court upheld constitutionality of statute of limitations in *Stephens v. Snyder Clinic Association* (1981); noneconomic damages cap ruled constitutional in *Samsel v. Wheeler Transport Services, Inc.* (1990); collateral source rule ruled unconstitutional in *Thompson v. KFB Insurance Company* (1993), Ks. Sup. Ct; earlier discretionary offset (1985, 1988) that applied only to medical liability actions struck down in *Farley v. Engleken (1987)*; 1965 cap on damage awards and periodic payment provision found unconstitutional in *Kansas Malpractice Victims v. Bell* (1988)
Kentucky	§413.140 (1974) 1 year from act or reasonable discovery, but not more than 5 years after act; minor and unsound mind: statute runs when disability lifted		§411.188.3 (1988) Discretionary offset of collateral sources except life insurance		§417.050 (1984) Written arbitration agreements enforceable and irrevocable			Kentucky Supreme Court ruled unconstitutional 5 year statute of limitation in *McCollum v. Sisters of Charity of Nazareth Health Corp.*(1990); collateral source rule overturned in *O'Bryan v. Hedgespeth* (1995)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Louisiana	§9.5628 (1975, 1987) 1 year from act or date of discovery, but no later than 3 years from date of injury; applies regardless of minority or disability; Civ. Code §2315.2 wrongful death: 1 year from death	$100,000 liability limit for qualified health care providers; punitive damages not recoverable, except in certain situations				§40.122.47 Medical review panel's report considered expert testimony		Appellate Court upheld the constitutionality of statute of limitation in *Valentine v. Thomas* (1983); Louisiana Supreme Court upheld the constitutionality of limits on damage awards in *Williams v. Kushner, slip. Op.* (1989), *Butler v. Flint Goodrich Hospital of Dillard University*, (1992); 1976 pretrial screening panel provision upheld in *Everett v. Goldman* (1978)
Maine	§24.2902 (1977) 3 years from cause of action; 6 years after accrual for minors or within 3 years of minority, whichever is first; foreign objects: accrue from reasonable discovery; incompetence: accrue upon lifting of disability	§18A.2.804 (1999, 1990) For wrongful death cases, non-economic damages limited to $150,000 and punitive damages limited to $75,000	§24.2906 (1990) Mandatory offset of collateral sources that have not exercised subrogation rights within 10 days after a verdict for the plaintiff	§24.2951 (1985) Mandatory periodic payments of future economic damages exceeding $250,000 at the request of a party	§24.2851-59 (1990, 1986-1989) Mandatory submission of medical injury claims to a "pre-litigation screening and mediation panel" except where all parties have agreed to bypass; any findings unanimous and unfavorable to the claimant as to both negligence and causation are admissible at any subsequent trial; for claims after January 1, 1991, panel's discovery is deemed court discovery at any subsequent trial		§24.2961 (1985-1987) Sliding scale fees may not exceed: third of first $100,000; 25% of next $200,000 and 20% of damages that exceed$200,000; for purpose of rule, future damages are to be reduced to lump-sum value	
Maryland	Cts. & Jud. Proc. §5.109 (1975) 5 years from act or 3 years from discovery, whichever is earlier; minors: statute begins at age 11; excepts reproductive system damage or foreign object injury; Cts. & Jud. Proc. §3.904 (1995) wrongful death: must be filed with 3 years of death	Cts. & Jud. Proc. §11.108 (1986, 1994) In any action for damages for personal injury accruing after October 1, 1994, $500,000 cap on non-economic damages; $620,000 cap in 2002 due to $15,000 increase every October 1 beginning in 1994; separate cap for each "direct victim"; wrongful death cases may not exceed 150% of cap		Cts. & Jud. Proc. §11.109 (1986) Discretionary periodic payment of future economic damages	Cts. & Jud. §3.2A.03-06 (1995) Discretionary submission of claims to a "health claims arbitration panel"; panel's decision on fault is "presumed to be correct" and its award is admissible as evidence at any subsequent trail; rejecting party liable to other for costs if verdict less favorable than findings	§3.2A.04 (1997) Within 90 days of filing, claimant must file certificate of expert consultation	Cts. & Jud. Proc. §3.2A.07 (1976) Court or pretrial screening panel will review disputed fees in medical injury actions	Damage award cap on non-economic damages ruled constitutional in *Murphy v. Edmonds*, 325 (1992)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Massachusetts	§§231.60D; 260.4, 7 (1986) 3 years from date of injury, but not more than 7 years from injury unless foreign object; minors: before age 6 until age 9; tolled for disability	§231.60H (1986) $500,000 cap for non-economic damages unless jury determines that there is "a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances"; if the total amount of general damages from a single occurrence for all plaintiffs exceeds $500,000, then the amount of such damages recoverable by each plaintiff will be reduced to a percentage of $500,000 proportionate to that plaintiff's share of the total amount	§231.60G (1986) Mandatory offset determined by the court		§231.608 (1975) Mandatory submission or medical injury claims to a "medical malpractice tribunal"; decision admissible at any subsequent trial; if tribunal finds against claimant, claimant must post $6,000 (or greater) bond for defendants costs if unsuccessful		§231.601 (1986) Sliding scale fees may not exceed: 40% of first $150,000, 33.33% of next $150,000, 30% of next $200,000 and 25% of damages that exceed $500,000; further limits if claimants recovery insufficient to pay medical expenses	Massachusetts Supreme Judicial Court upheld the constitutionality of pretrial screening panel requirement in *Paro v. Longwood Hospital* (1977)
Michigan	600.5838a, 5851(1846-1986) 2 years from injury or 6 months from reasonable discoverability, whichever is later, not to exceed 6 years; 6 years tolled for fraud or reproductive systems; disabled plaintiff: 1 year after injury except in cases of reproductive injury; foreign object: 6 months; minors under age 8: 6 years from date of occurrence or age 10, whichever is later (if action brought after 10th birthday, must be within the 6 year limit)	§600.1483 (1986) After April 1, 1994, $280,000 cap on noneconomic damages, $500,000 cap for non-economic damages applies to certain other circumstance; caps adjusted annually for inflation; in 2002, caps are $349,700 and $624,500, respectively	§600.6303 (1986) Mandatory offset of collateral sources, except life insurance, admissible after a verdict for plaintiff	§600.5056 (1975) third of a medical malpractice arbitration award, unless parties stipulate awards in excess of $50,000, to be paid lump sum; §600.6307 (1986) mandatory periodic payment of future economic damages excluding future medical, other health care costs and collateral source benefits; future non-economic damages reduced to gross percent cash value	§600.4903,15, 17, 21 (1987) Mandatory review by medication panel; party rejecting panel's evaluation must pay opposing party's actual cost unless verdict more favorable than panel; §600.2912g (1975) parties may enter into binding arbitration if total damages claimed are less than $75,000	§600.2912 Expert must be a licensed health professional, practice in a similar specialty, be board certified (if required on specialty), during the year preceding action had clinical or academic experience in specialty; certificate of consultation must be filed	Mich. Court Rules 8.121(b) (1981) Maximum contingency fee for a personal injury action is third of the amount recovered	
Minnesota	§541.07 (1935, 1982) 2 years from injury or termination of treatment; tolled for insanity; infant's claim must be asserted within 7 years from injury or 1 year after age of majority		§548.36 (1986) Mandatory offset of collateral sources by court if defendant brings in evidence of payments made to plaintiff	§549.25 (1988) Discretionary periodic payment of future damages in excess of $100,000		§145.682 (1989) Claimant must file an affidavit stating that an expert has been consulted		Eighth Circuit has upheld the constitutionality of the statute of limitation in *Jewson v. Mayo Clinic* (1982)
Mississippi	§15.1.36 (1976) 2 years from act or reasonable discovery, within 7 years after the act; mentally incompetent plaintiffs: 2 years after disability ceases; minors under 6: 2 years after age 6 or death, whichever is first; tolled for insanity					§11.1.61 (1990) Expert witness must be licensed physician		

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Missouri	§516.105 (1976) 2 years from act, foreign object: 2 years from discovery; in no event longer than 10 years from act or 10 years from minor's 20th birthday, whichever is later; minor under 8: until age 20	§538.210 (1986) Cap on non-economic damages adjusted annually for inflation; set at $547,000 in 2002		§538.220 (1986) Mandatory periodic payment of future damages over $100,000 at the request of party		§538.225 Affidavit of expert consultation must be filed within 90 of filing of filing action		Supreme Court of Missouri upheld constitutionality of statute of limitation in *Ross v. Kansas City Gen. Hosp. & Med. Ct.* (1980); statute of limitation from minors :2 and older ruled unconstitutional in *Strahler v. St. Luke's Hospital* (1986); limit on damage awards upheld in *Adams v. Childrens Mercy Hospital* (1991); pretrial screening panel provision overturned in *State ex rel. Cardinal Glennin Memorial Hospital v. Gaertner* (1979)
Montana	§27.2.205 (1971) 3 years from injury or discovery; in no event more than 5 years from act; tolled against a potential plaintiff where there has been a failure of disclosure of the act; minors under age 4: 3 years of age 8 or death, whichever occurs first	§25.9.411 (1995) court to impose a $250,000 limit any jury award for non-economic damages, for causes of action arising as of Oct. 1, 1995	§27.1.308 (1987) Mandatory offset of collateral sources by judge for awards greater than $50,000, in bodily injury and death cases	§25.9.4.3 (1995) Mandatory periodic payment at the request of party for awards in excess of $50,000, as of Oct. 1, 1995; in case of death, payments property of estate	§27.6.701 (1977) Mandatory review by Medical Legal Panel for actions not subject to valid arbitration agreement; panel report neither binding nor admissible at trial			Montana Supreme Court upheld the constitutionality of the pretrial screening panel statute in *Linder v. Smith* (1981)
Nebraska	§§25.222; 44.2828 (1976, 1996) 2 years from act or 1 year from reasonable discovery, but no more than 10 years after date of act; §25.213 under 21 or mentally disabled: statute runs from removal; §30.810 wrongful death: 2 years from death	§44.2825 (1976, 1986) $1 million limit on recoveries against health care providers qualifying for state-sponsored excess insurance; fundamental rule of Nebraska law prohibits punitive, vindictive, or exemplary damages	§44.2819 (1976) Non-refundable medical reimbursement insurance benefits credited against judgement, in certain actions		§44.2840-1 (1976) Mandatory review of medical injury claims except where plaintiff affirmatively waives his right to panel hearing; the panel report is admissible in any subsequent trial		§44.976 Court review for reasonableness of attorney fees in cases against health care providers	Nebraska Supreme Court upheld the constitutionality of the limit on damage awards, collateral source rule and pretrial screening panel requirement in *Prendergast v. Nelson* (1977)
Nevada	§41A.097 (2002, 1989, 1985) 3 years from injury or 2 years from reasonable discovery, whichever is first; tolled for concealment; minors: statute runs until age 10 for brain damage or birth defects; if sterility alleged, statute runs 2 years after discovery; tolled for insanity or minors ward of state	§42.005 (1996) $300,000 or 3 times compensatory damages cap on punitive damages, only awarded for fraud, oppression, or malice; §41A (2002) $350,000 cap on non-economic damages with exception for cases of gross malpractice (effective October 1, 2002); limits damages for hospitals and doctors to $50,000 when treating trauma patients	§42.020 Damages against health care providers reduced by amount of any prior payment by health care provider to the claimant; mandatory offset	§42.020 (2002, 1985) Claimant may elect to receive award for future damages in a lump sum reduced to present value, if approved by the court, or as an annuity; or by other means if the defendant posts an adequate bond or other security to ensure full payment	§41A.003-069 (2002) Abolished the mandatory submission of claims to pretrial screening panel; decision and findings were admissible at subsequent trial; unfavorable ruling made claimant responsible for defendant's court cost, if lost at trial	§41A.800 (2002) District court must dismiss cases filed without an affidavit to support allegations submitted by a medical expert who practices or has practiced in an area similar to the practice related to the alleged malpractice	§7.085 (2002, 1995) Court shall require attorneys to personally pay for the cost of expenses that result from their unreasonable conduct in civil litigation	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
New Hampshire	§507.C:4 2 year limit specific to medical malpractice found unconstitutional; §§508:4,8 (1986) 3 years from injury or reasonable discovery, infant or incompetents: 2 years from removal of disability	§507.C:7 (1977) $250,000 cap on non-economic damages; §556:13 $50,000 cap on wrongful death damages and restricted to immediate or dependent family members; after 1998, wrongful death cap raised to $150,000 and restricted to surviving spouse; §507:16 punitive damages prohibited	§507.C:7(I) (1977) Abolishes collateral source rule in medical malpractice cases	§524:6.a (1997) Periodic payment awarded at court discretion		§507.E.2 (1997) Claimants must provide expert testimony to support their claims	§508:4.e (1986) Fees for actions resulting in settlement or judgement of $200,000 or more shall be subject to court approval	New Hampshire Supreme Court struck down as unconstitutional the limit on non-economic damage awards, mandatory offset of collateral sources, and earlier provisions for discretionary award of periodic payment of future damages and attorney fees in *Carson v. Maurer* (1980); $875,000 limit on non-economic damages found unconstitutional in *Brannigan v. Usitalo* (1991)
New Jersey	§2A:14.2, 14.23 (1987) 2 years from accrual of claim or discovery; under 21 or insane: runs upon removal; wrongful death: 2 years from death, 6 months after the death is not computed as part of the time period	§2A:15.5.14(b) (1997) punitive damages cap of $350,000 or 5 times compensatory damages, whichever is greater	§2A:15.97 (1987) Mandatory offset of collateral sources, excluding workers' compensation or life insurance, admissible at trail and deductible from any verdict for plaintiff		§4:21A.1-8 (1985) Voluntary arbitration of medical claims by written agreement, if claim under $20,000	§2A.53A.27 Affidavit of consultation of expert must be filed within 60 days of filing action	Court Rules §1:2107 (1976) Sliding scale fees may not exceed third of first $500,000, 30% of second $500,000, 25% of third $500,000 and 20% of fourth $500,000; 25% cap for a minor or an incompetent plaintiff	New Jersey Supreme Court upheld the constitutionality of a 1978 pretrial screening panel statute in *Perna v. Pirozzi* (1983)
New Mexico	§41.5.13, 22 (1976) 3 years from injury; minors under 6: until age 9 to file suit; applies to all persons regardless of minority or disability; the statute is tolled upon submission to hearing panel and shall not run until 30 days after panel final decision	§41.5.6-7 (1976) $600,000 ($500,000 for acts prior to April 1995) cap to all damages, excluding punitive damages and medical care and related costs; health care providers not liable for any amount over $100,000; future medical expenses not be awarded as monetary damages		§41.5.7 (1976) Mandatory periodic payment of damages for future medical care up to $200,000, after which patient's compensation fund must pay	§41.5.14-20 (1976) Mandatory submission of medical injury claims to a hearing panel; panel report is not admissible at any subsequent trial			
New York	CVP §214.a (1975) 2 1/2 years from injury or from last treatment where there is continuous treatment for condition giving rise to claim; foreign object: 1 year from discovery; incompetence tolls statute for maximum 10 years		Civ. Prac. §4545 (1981) Mandatory offset of collateral sources made by the court	Civ. Prac. §5031-5039 (1985) Mandatory periodic payment of future damages in excess of $250,000; parties may agree to lump sum payment; pain and suffering damages paid within a period no longer than 10 years	CPLR §3045 (1991) Defendant may concede liability if plaintiff agrees to arbitrate; if plaintiff refuses, defendant's concession of liability cannot be used for any other purpose; Public Health §4406.2 HMOs can put arbitration clauses in contracts, but not as a condition of joining	§3012.A Certificate of consultation of expert must be filed within 90 days of filing complaint	Jud. §474a (1985) Sliding scale fees may not exceed 30% of first $250,000, 25% of second $250,000, 20% of next $500,000, 15% of next $250,000 and 10% over $1.25 million	New York's highest court upheld the constitutionality of a pretrial screening panel statute in *Treyball v. Clark* (1985)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
North Carolina	§1.15 (1979) 3 years from act or 1 year from reasonable discovery, but not more than 4 years after injury; foreign object: 1 year from discovery, but not more than 10 years from last act; wrongful death: 2 years from death	§1D.25 (1995) Punitive damages cap of $250,000 or 3 times compensatory damages, whichever is greater			§7A.38.1 (1997) Mandatory mediation	§90.21.12 (1990) Expert must testify to community standard of care; §8C.1 Rule 702 expert must be licensed		North Carolina Court of Appeals upheld the constitutionality of the statute of limitations in *Roberts v. Durham County Hospital Corp.* (N.C. App. 1982)
North Dakota	§§28.01.18, 25 (1975) 2 years from act or reasonable discovery, but not more than 6 years after act, unless concealed by fraudulent conduct of defendant; disability, except minority, tolls statute for 5 years, in no case after 1 year from removal of disability or 6 years total; minors: 12 years	§32.42.02 (1995) $500,000 cap on non-economic damages; §32.03.2.08 economic damage awards in excess of $250,000 subject to court review for reasonableness	§32.03.2.06 (1987) Discretionary offset of collateral sources, excluding life insurance, death or retirement benefits or any insurance purchased by recovering party	§32.03.2.09 (1987) Discretionary periodic payment of future economic damages for continuing institutional or custodial care for a period of more than two years; adequacy of payments subject to continuing court review	§32.42.03 (1996) Attorneys must disclose alternative dispute resolutions option; good faith effort to resolve dispute required	§28.01.46 A claimant is required to obtain supportive expert opinion within 3 months of filing complaint		A $300,000 limit on medical liability awards and an earlier discretionary offset in cases involving $100,000 or more were struck down as unconstitutional in *Arneson v. Olson* (N.D. 1978)
Ohio	§2305.11 B(1) (1990) 1 year after reasonable discovery; if plaintiff gives written notice before the 1 year expires, suit may be brought within 180 days of the notice; persons with legal disability must bring suit within 4 years after occurrence; for actions accruing as of Jan. 27, 1997, 6 year statute of repose; minor, unsound mind, or imprisoned: tolled until disability removed; wrongful death: 2 years from death	§2323.54 (1997) as of Jan. 27, 1997, non-economic cap of $250,000 or 3 times economic damages up to $500,000, whichever is greater; for more serious loss, $1 million or $35,000 times remaining life expectancy; §2315.21 (1997) punitive damages cap or $100,000 or 3 times compensatory damages, except for defendants that employ more than 25 persons, for whom cap is $250,000 or 3 times compensatory damages; prohibits punitive damages if defendant already paid amount of cap of punitive damages in another case	§23 (1975) Evidence of collateral sources in medical actions, except for insurance benefits paid for by plaintiff or employer (but including workers' compensation), admissible at trail	§2323.57 (1987) Mandatory periodic payment of future damages over $200,000 at request of party	§2711.21 (1975, 1987) Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties; decision is not admissible at any subsequent trial; prior to 1987 amendment, submission was mandatory and results were admissible	§2743.43 (1975) Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching; §2305.01.1 claimant must file certificate of consultation with expert		Ohio Supreme Court ruled unconstitutional a comprehensive tort reform package passed in 1997 that included noneconomic damage caps in *Ohio Academy of Trial Lawyers v. Sheward* (1999); a $200,000 limit on general damages struck down in *Morris v. Savoy* (1991); a $250,000 limit on non-economic damages overturned in *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the 8th District twice upheld the collateral source rule in *Morris, et al. v. Savoy* (1991) and *Charles William May v. Tandy Corp., et al* (1993) and *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the Court of Appeals of Ohio (11th District) struck down collateral source rule in *Schenk v. The Cleveland Electric Illuminating Company* (1994); Ohio Supreme Court upheld the 1975 pretrial screening panel statute in *Beatty v. Akron City Hospital* (1981)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Oklahoma	§§76.18 (1987) 2 years from reasonable discovery, after 3 years from act, recovery limited to past and future actual medical and surgical expenses; §12.96 (1988) minors under 12: 7 years; minors over 12: 1 year after attaining majority but in no event less than 2 years from injury; incompetents: 7 years from injury unless adjudged incompetent, then 1 year after such adjudication, but in no event less than 2 years from injury	§23.9.1 (1998) $100,000 cap on punitive damages for reckless disregard; punitive damages cap of $500,000, 2 times compensatory damages, or benefit derived by defendant from his conduct for intentional and malicious acts (waived in certain circumstances); discretionary waiver of damages by court if defendant already paid punitive damages for same action	Discretionary offset of collateral sources				§5.7 (1953) Maximum percentage: fee may not exceed 50% of net judgement	Oklahoma Supreme Court upheld 2.year statute of limitations as constitutional in *McCarroll v. Doctors General Hospital* (1983); 3 year statute of repose on all damages other than past and future medical and surgical expenses ruled unconstitutional in *Wofford v. Davis* (Okla. 1988); earlier limit on damage awards struck down in *Reynolds v. Porter* (1988)
Oregon	§§12.110;160 (1988) 2 years from reasonable discovery; but not more than 5 years from act; fraud: 2 years from reasonable discovery; minors or insane: 5 years from accrual or 1 year after disability ceases; wrongful death: 3 years from death or reasonable discovery	§18.540, 560 (1987) $500,000 cap on non-economic damages (overturned except with regard to wrongful death); §18.550 (1989) no punitive damages awarded against licensed physician unless malice is shown; 60% of punitive damages paid to Criminal Injuries Compensation Account	§18.580 (1987) Discretionary offset after judgement of collateral sources by court, except benefits plaintiff must repay, life insurance, retirement, disability, pension plans or social security				§18.540 Attorneys fees from punitive damages may not exceed half the claimant's 40%	Oregon Supreme Court ruled non-economic damages cap unconstitutional, except in wrongful death suits, in *Lakin v. Senco Products, Inc* (1999)
Pennsylvania	§42.5524 (1975) 2 years from injury or reasonable discovery; §42.5533 minor: 2 years after age of majority	§40.1301.812.A(g) (1997) Effective Jan. 25, 1997, punitive damages cap of $100,000 or 2 times compensatory damages; members of Medical Professional Liability Catastrophe Loss Fund, in effect, subject to limited liability			§40.1301.825A (1975) Mandatory "conciliation hearing", which may be a settlement conference or mediation as the parties prefer	§1301.821.A Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position		Pennsylvania Supreme Court found a statute providing for a mandatory offset of collateral sources in medical liability actions unconstitutional by the in *Mattes v. Thompson* (1980); earlier mandatory pretrial screening panel struck down in *Mattes v. Thompson* (1980); panels may exist as long as participation is voluntary and the outcome is not binding; attorney fee limits struck down in *Heller v. Frankston* (1984)
Rhode Island	§§9.1.14.1; 10.7.2 (1976, 1988) 3 years from injury, death or reasonable discovery; minors and incompetents: 3 years from removal of disability	§9.1.8 (1997) Punitive damages not recoverable against executor or administrator of an estate; §9.19.41 (1997) $100,000 minimum recovery in any wrongful death action	§9.19.34.1 (1986) Mandatory offset by court in medical liability actions, if evidence is admitted	§9.21.12-13 (1986) Mandatory conference on periodic payment where judgment exceeds $150,000		§9.19.41 (1997) expert must have training/ education to qualify as an expert		Pretrial screening panels were found unconstitutional in *Boucher v. Sayeed* (1983)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
South Carolina	§15.35.45, 15.3.40 (1977-1988) 3 years from injury or reasonable discovery, but not more than 6 years after act; foreign object: 2 years from discovery; minors: tolled, but no more than 7 years from act or 1 year from majority; tolled for disability, up to 5 years or 1 year after disability ceases							
South Dakota	§15.2.14.1, 221 (1984) 2 years from injury; tolled for fraud or foreign object until end of treatment; tolled for minority for 3 years or until age 8 if under age 6; metal illness: tolls statute up to 5 years; 1 year from removal; wrongful death: 3 years from death	§21.3.11 (1997, 1985) $500,000 cap on non-economic damages	§21.3.12 (1977) Discretionary offset in medical liability cases, except benefits that have a right if subrogation or were paid for by plaintiff	§21.3A.1-12 (1986-1988) Mandatory periodic payment of future damages in excess of $200,000 or past and future damages of $500,000, whichever is less; discretionary at the request of a party	§21.25B.1 (1976) Parties may agree to arbitrate for past and future services; revocable as to future services			The South Dakota Supreme Court rejected the discovery rule in *Alberts v. Giebink* (1980); law reducing statute of limitation for minors ruled unconstitutional in *Lyons v. Lederle Laboratories* (1989); $1 million cap on total damages ruled unconstitutional, reviving prior $500,000 cap on noneconomic damages, in *Knowles v. U.S.* (1996)
Tennessee	§29.26.116 (1975) 1 year from discovery, but no more than 3 years from act unless foreign object; foreign object: 1 year from discovery; under 18 or unsound mind: 1 year from removal		§29.26.119 (1975) Mandatory offset except for assets purchased by plaintiff or private insurance		§29.5.101 All causes of action may be submitted to the decision of arbitrators except wher 1 of the parties is an infant or a person of unsound mind	§29.26.115(b) (1975) Expert witness must be licensed in Tennessee or contiguous state and practice for one year preceding date of injury	§29.26.120 (1975) Plaintiff's attorney fees in a medical injury suit shall not exceed third of all damages awarded	Tennessee Supreme Court upheld the constitutionality of statute of limitation in *Harrison v. Schrader* (1982)
Texas	Civ. §4590i.10.01 (1977) 2 years from occurrence (discovery); minors under 12: until age 14; otherwise applies to all regardless of minority or disability	Civ. §4509.11.02-04 (1977) approximately $1.3 million cap on wrongful death damages, adjusted annually for inflation; Civ. Prac. & Rem. §41.008 (1995) punitive damages cap as of Sept. 1, 1995 of 2 times economic damages, plus non-economic damages (not to exceed $750,000), or $200,000, whichever is greater, with certain exclusions				§14.01 Expert must have experience relating to complaint; Tex. Rev. Civ. Stat. Ann. 4590I, §13.01 plaintiff must post file on expert w/in 90 days of filing		The Texas Supreme Court struck down limit on damage awards as unconstitutional in *Lucas v. United States* (1988); limit subsequently found constitutional only in wrongful death cases in *Rose v. Doctors Hosp.* (1990)

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Utah	§78.14.14 (1985) 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	§78.14.7.1 (1986) $250,000 cap on non-economic damages	§78.14.4.5 (1985) Mandatory offset by court except for benefits where subrogation rights exist	§78.14.9(5) (1986) Mandatory periodic payment of future damages that exceed $100,000, exclusive of attorneys' fees and costs	§78.14.8-16 (1985) Decision of pre-litigation panel may be considered binding arbitration upon written agreement of parties; mandatory submission of claims to panel; panel recommendations not admissible at subsequent trial		§78.14.7(5) (1985) Contingency fee shall not exceed third of award	Utah Supreme Court ruled unconstitutional the minority provision of the statute of limitation in *Lee v. Dr. Lynn Craufin*; *Griffith v. Dr. J. Dallas Van Wagoner* (1993); this reversed an earlier decision in *Allen v. International Health Care, Inc.* (1981)
Vermont	§12.521, 551 (1977) 3 years from injury or 2 years from reasonable discovery, but no more than 7 years from act, excluding concealment and foreign objects; foreign object: 2 years from discovery; tolled until removal of disability				§12.7002 (1995) Mandatory submission to pretrial arbitration panel; findings subject to appeal unless parties agree to binding arbitration			
Virginia	§8.01.229, 243 (1959, 1987) 2 years from injury, but not more than 10 years from act; foreign object or fraud: 1 year from reasonable discovery; infants: 5 years from date of accrual of cause of action; for claims accruing on or after July 1, 1987, minors under 8: age 10; age 8 or older: 2 years after last treatment unless; minors who were 10 or older on or before July 1, 1987: 2 years from that date to bring an action	§8.01.581.15 (1976-1983) $1.5 million cap on recovery damages for bodily injury or death, shall increase on July 1, 2000 by $50,000 and every July 1 after that until 2007 and 2008 when the final increases will be $75,000 per year; cap applies for each injury, regardless of number of theories or defendants; §8.01.38.1 (1992) $350,000 cap on punitive damages		§8.01.424 Periodic payment of awards permitted, if reviewed by court and secured by bond or insurance	§8.01.581.2, 8 (1997) Review by pretrial panel by request; findings non-binding; testimony of panel members, except chair, admissible; §8.01.581.12 (1997) parties permitted to agree in advance of treatment to binding arbitration, with period of patient withdraw	§8.01.581.20 (1992) Claims must be supported by expert testimony; physicians must have had an active clinical practice in the field about which he will testify within year of incident		Virginia Supreme Court upheld constitutionality of a prior $750,000 cap on damage awards in *Etheridge v. Medical Center Hospitals* (1989); pretrial screening panel statute upheld as constitutionality in *Speet v. Bauaj* (1989)
Washington	§4.16.350 (1971, 1988) 3 years from injury or 1 year from discovery, whichever is later, but no more than 8 years after act; fraud, concealment or minority toll statute, foreign object: 1 year from discovery; wrongful death: 3 years from death	§4.56.250 (1986) Noneconomic damages in person injury suit may not exceed an amount determined by multiplying 0.43 by the average annual wage in state and by the life expectancy of the person incurring noneconomic damages; a plaintiff's life expectancy shall not be less than 15 years for the purpose of determining maximum noneconomic damages	§7.70.080 (1976) Information on collateral sources may be introduced except for insurance purchased by plaintiff or employer	§4.56.260 (1986) Mandatory periodic payments in personal injury actions of future economic damages of $100,000 or more			§7.70.070 (1976) In any medical injury the court shall determine the reasonableness of each party's attorney fees	Washington Appellate Court upheld constitutionality of statute of limitation on constitutional in *Duffy v. King Chiro. Practice Clinic* (1977); limit on damage awards struck down in *Sofie v. Fibreboard Corporation* (1989)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
West Virginia	§55.7B.4 (1986) 2 years from injury or reasonable discovery, whichever occurs last; in no event longer than 10 years after injury; minors under 10: 2 years from injury or by age 12, whichever provides a longer period; statute tolled for any period during which fraud or concealment prevents discovery	§55.78.9 (1986) $1 million cap on non-economic damages; court must instruct jury				§55.75.7 (1986) Expert witness must be licensed physician and engaged in the same or substantially similar medical field as defendant		West Virginia Supreme Court upheld constitutionality of limit on damage awards in *Robinson v. Chaleston Area Medical Center* (1991)
Wisconsin	§893.55, 56 (1979) 3 years from injury or 1 year from discovery, but not more than 5 years from act; foreign object: 1 year from discovery or 3 years from act, whichever is later; minors: by age 10 or standard provision, whichever is later	§893.55(4)(d) (1995) For acts as of May 25, 1995, $350,000 cap adjusted annually for inflation for non-economic damages, excluding wrongful death cases, which are limited to $500,000 for a child and $350,000 for an adult	§893.55(7) Effective May 25, 1995, collateral source information is admissible at trial	§655.015 (1986, 1995) For settlement or judgement for act occurring on or after May 25, 1995 in excess of $100,000, award paid into interest baring fund, from which periodic payments are made	§655.42, 442-5 (1985, 1989) Voluntary submission of medical injury claims to mediation panel; findings of panel inadmissible at subsequent court action		§655.013 (1986) Sliding scale may not exceed: third of first $1 million or 25% or first $1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding $1 million	The Wisconsin Supreme Court upheld the constitutionality of earlier statute of limitation in *Rod v. Farrell* (1980); earlier cap on non-economic damages ruled unconstitutional in *Jelenik v. The Saint Paul Fire and Casualty Insurance Company* (1994); periodic payment awards upheld in *State ex re. Strykowski v. Wilkie* (1978)
Wyoming	§1.3.107, 1.38.102 (1977) 2 years from injury or reasonable discovery; minors: until age 8 or within 2 years, whichever is later; legal disability:1 year from removal; wrongful death: 2 years from death	Limits on damage awards prohibited by state constitution					Ct. Rules, Contingent Fee R. 5 (1997) Where recover is $1 million or less: third if claim settled prior 60 days after filing, or 40% if settled after 60 days or judgement; 30% over $1 million	Wyoming Supreme Court struck down the 1986 pretrial screening panel statute requiring mandatory submission of all medical injury claims to a "medical review panel" in *Hoem v. Wyoming* (1988)

Sources: National Conference of State Legislatures (September 2002)
McCullough, Campbell and Lane, *Summary of United State Medical Malpractice Law*, available on the Web at http://www.mcandl.com/states.html
American Tort Reform Association (ATRA)

For more information, please contact:
Cheye Calvo or Stephanie Norris
National Conference of State Legislatures
(202) 624-5400

rural doctors to boost prenatal, childbirth care

By Peter Aleshire
The Arizona Republic

State subsidizing of doctors delivering babies in some areas of rural Arizona would save money and lives, according to a report released Thursday by the University of Arizona College of Medicine.

Some action is urgently needed because 23 rural communities with populations greater than 2,000 now have no doctors to deliver babies, according to Rena Gordon, a researcher from UA's Rural Health Office.

Gordon said the 83 rural doctors still delivering babies cannot continue to do so much longer.

"They're at the end of their rope," Gordon said.

Gordon provided a range of proposals to keep doctors delivering babies in underserved areas by subsidizing their malpractice insurance premiums. Those costs range from about $25,000 to nearly $120,000, depending how many babies the doctors deliver.

Gordon's proposals carry price tags ranging from $200,000 to $4 million. The $200,000 would pay doctors to assist midwives, and the $4 million would cover the cost of malpractice insurance for 83 obstetricians and family practitioners delivering babies.

Gordon's survey revealed that most of the doctors still in practice and 26 of the 60 rural doctors who have quit delivering babies in the past three years would be likely to resume delivering babies if their malpractice premiums were subsidized.

However, state health officials said that there is little chance that the subsidies will be considered this year.

"At this late date, we can't do anything that costs money," said Dr. Glyn Caldwell, deputy director of the state Department of Health Services.

Gov. Rose Mofford last week ordered the department to set up a

— *See* **STATE**, *page B2*

RETURN TO ALS ARTICLE

1989

THE ARIZONA REPUBLIC
FRIDAY, MARCH 3, 1989

★★

State urged to boost rural prenatal, birth care

— **STATE**, *from page B1*

system to transport women in areas with no doctor to those where they could obtain care. But Caldwell said the order applies only to women near delivery, not to women who need prenatal care.

Last year, 300 babies born prematurely in rural Arizona were flown to hospitals with neonatal intensive-care units in Maricopa County, said Dr. Belton Meyer, a medical director of the Arizona State Newborn Transport and Intensive Care Program. An additional 238 mothers in premature labor also were flown to those hospitals. In addition, about 100 babies were flown to hospitals in Pima County, he said.

It costs an average of about $42,000 to care for a premature baby, said Dr. Michael Clements, director of Regional Services for Phoenix Children's Hospital. That puts the total bill for babies born prematurely in rural Arizona at roughly $16.8 million.

Women who receive inadequate prenatal care are four times more likely to give birth prematurely than those who receive adequate care, Clements said.

Dr. John Elliot, a perinatologist at Phoenix Children's Hospital, said any steps to keep doctors delivering babies in rural Arizona would help but would only stave off disaster in a state where 8 percent of the babies are already born prematurely, a rate above the national average.

"It would help, no question about it," Elliot said. "But it's a cruel joke that all we're talking about is preserving the status quo, which is completely unacceptable."

A third of the women giving birth in Arizona last year had inadequate prenatal care, which ranks Arizona 44th in the nation in the percentage of women receiving proper prenatal care, according to the state Department of Health Services.

Communities with no doctors to provide prenatal care or deliver babies include West Sedona and Williams in Coconino County; Wickenburg in Maricopa County; Apache Junction in Pinal County; Camp Verde and Prescott Valley in Yavapai County; Benson in Cochise County; Edgar in Apache County; and Thatcher in Graham County.

BALLOT FORMAT

PROPOSITION 102

PROPOSED AMENDMENT TO THE CONSTITUTION BY THE LEGISLATURE

OFFICIAL TITLE

SENATE CONCURRENT RESOLUTION 1004

A CONCURRENT RESOLUTION PROPOSING AN AMENDMENT TO THE CONSTITUTION OF ARIZONA; AMENDING ARTICLE IX, SECTION 13, CONSTITUTION OF ARIZONA; RELATING TO PROPERTY TAX EXEMPTION.

DESCRIPTIVE TITLE

AMENDING ARIZONA CONSTITUTION TO PROVIDE A PERSONAL PROPERTY TAX EXEMPTION FOR LIVESTOCK, POULTRY, AQUATIC ANIMALS AND HONEYBEES OWNED BY A PERSON PRIMARILY INVOLVED IN AGRICULTURAL PRODUCTION, SUBJECT TO CONDITIONS THE LEGISLATURE MAY SET.

PROPOSITION 102

A "yes" vote shall have the effect of allowing the Legislature to provide a personal property tax exemption for a person who owns livestock, poultry, aquatic animals and honeybees and is principally engaged in agricultural production. YES ➡

A "no" vote shall have the effect of not allowing the Legislature to provide a personal property tax exemption for a person who owns livestock, poultry, aquatic animals and honeybees and is principally engaged in agricultural production. NO ➡

PROPOSITION 103

OFFICIAL TITLE
AN INITIATIVE MEASURE

PROPOSING AN AMENDMENT TO THE CONSTITUTION OF ARIZONA; AMENDING ARTICLE II, SECTION 31, CONSTITUTION OF ARIZONA; AMENDING ARTICLE XVIII, SECTION 5, CONSTITUTION OF ARIZONA; AMENDING ARTICLE XVIII, SECTION 6, CONSTITUTION OF ARIZONA, RELATING TO CIVIL JUSTICE REFORM.

TEXT OF PROPOSED AMENDMENT

Be it enacted by the People of the State of Arizona:

The Constitution of Arizona is proposed to be amended as follows, by amending Article II, section 31; Article XVIII, section 5; Article XVIII, secti n 6, if approved by the voters and on proclamation of the Governor:

Section 1. Article II, section 31, Constitution of Arizona is amended to read:

31. Damages for death or personal injuries

Section 31. ~~No~~ A law ~~shall~~ MAY be enacted in this State limiting the amount of damages to be recovered for causing the death or injury of any person.

Section 2. Article XVIII, section 5, Constitution of Arizona is amended to read:

5. Contributory negligence and assumption of risk

Section 5. UNLESS OTHERWISE PROVIDED BY LAW, the defense of contributory negligence or of assumption of risk shall~~, in all cases whatsoever,~~ be a question of fact and shall~~, at all times,~~ be left to the jury.

Section 3. Article XVIII, section 6, Constitution of Arizona is amended to read:

6. Recovery of damages for injuries

Section 6. The right of action to recover damages for injuries ~~shall never~~ MAY be abrogated, and the amount recovered ~~shall not~~ MAY be subject to ~~any~~ statutory limitation.

ANALYSIS BY LEGISLATIVE COUNCIL
(In compliance with A.R.S. section 19-124)

The Constitution of Arizona provides that no law limiting or prohibiting the right to sue for death or injury and no law limiting the amount of m ney to be recovered can be enacted. The Constitution of Arizona also provides that in a lawsuit the jury determines all questions relating to the legal defense of "contributory negligence" or "assumption of risk".

Proposition 103 would amend the Constitution of Arizona to:

1. Allow the Legislature or the people to enact laws that could limit or prohibit a person from bringing a lawsuit to recover money or benefits for injuries;
2. Allow the Legislature or the people to enact laws that could limit the amount of money or benefits a person could recover for death or personal injuries, and
3. Allow the Legislature or the people to enact laws that could rem ve the defense of "contributory negligence" or "assumption of risk" from the consideration of a jury.

ARGUMENT "FOR" PROPOSITION 103

Arizona is one of the few states in the country where prisoners, drunk drivers and criminals can sue their victims – that's absurd. A "YES" vote on Proposition 103 will put a stop to these types of absurdities, so you can't be sued by a criminal or a drunk driver.

Henry Evans, Chairman
People for a Fair Legal System
Cotton Farmer
Cashion

ARGUMENT "FOR" PROPOSITION 103

It is time we put a stop to the madness and absurdity in our legal system. The people of Arizona deserve a legal system that protects us from frivolous lawsuits. We need a legal system that is fair and responsive to our people. Voting Yes on Proposition 103 will help us fix our out of control legal system.

On behalf of the Arizona Chamber of Commerce I urge you to vote Yes on Proposition 103.

Clint Magnussen, Chairman of the Board
AZ Chamber of Commerce
Phoenix

Wayne C. Anderson, President and CEO
AZ Chamber of Commerce
Phoenix

ARGUMENT "FOR" PROPOSITION 103

Modifications of these three outdated sections of the Arizona State Constitution will go a long way towards helping victims better protect themselves from being sued by their attackers."

Stephanie Orr, Executive Director
Center Against Sexual Abuse
Phoenix

Maria Hoffman, Board Member
Center Against Sexual Abuse
Phoenix

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

The future of recreational trails in Arizona and the preservation of our Western way of life depends on the passage of this proposition. Without the modifications and updates of our outdated legal system that this initiative will bring, the liability concerns of private landowners may force the closure of some of our state's most popular hiking, horseback riding and mountain biking trails, and the effect on our quality of life will be tremendous. We urge you to support this constitutional reform proposition.

Deborah Suppes, President
Pima Trails Assn
Tucson

Steve Anderson, Vice President
Pima Trails Assn
Palo Verde

ARGUMENT "FOR" PROPOSITION 103

Senate Bill 1305 will protect volunteers who work for many worthy organizations, such as Arizona Special Olympics, from frivolous liability lawsuits that arise from their volunteerism. However, Senate Bill 1305 will become law only if Proposition 103 is passed. Generous volunteers acting in good faith should not have to worry about frivolous lawsuits.

John H. Coomer, Executive Director
AZ Special Olympics
Phoenix

Richard L. Vogel, Chairman
AZ Special Olympics
Phoenix

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

I support this initiative because it will allow previously-passed legislation dealing with volunteers to be more effective. This initiative will help protect nonprofit and public agencies and their volunteers from frivolous lawsuits. It will remove some barriers that prevent citizens from volunteering.

Lucia Causey, Executive Director
Volunteer Center of Maricopa County
Tempe

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

This amendment will support legislation that will protect 501(c)(3) charitable organizations and their volunteers from frivolous liability lawsuits, gross negligence notwithstanding. With these invaluable protections, Arizona Not-For Profit Organizations will not have to waste their precious resources defending themselves from ridiculous lawsuits; and civic minded individuals will not be threatened by ridiculous lawsuits because they wish to volunteer their time to support community projects.

Maria Hoffman, Executive Director
AZ Council of Centers for Children and Adolescents
Phoenix

Darlene Dankowski, Co-Chair
AZ Council of Centers for Children and Adolescents Legislative Committee
Phoenix

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

As a 27 year adult volunteer to youth sports programs in Arizona, I fully support the provisions of this proposition, specifically regarding the Adult

districts obtain by
all of the problems of our youth of
their time, because
well intended, and not

Director of
Football Federation, Inc.

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

If the frivolous law suits are allowed to continue, the cost to the Taxpayers will continue to rise. In order to live in a free society we must not be in fear of frivolous cost to family and estate for our efforts to volunteer and serve in our communities.

Richard R. Wiesler, Director
Sun City Taxpayers Assn, Inc.
Sun City

Preston E. Welch, 1st Vice President
Sun City Taxpayers Assn, Inc.
Sun City

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

Fixing the outrageousness in our legal system will go a long way towards protecting the services that Arizona's towns and cities provide their people. As a former mayor of Tolleson, Arizona, as a homeowner and as a taxpayer who works hard for his money (I'm a barber), I know what phony lawsuits, or the threat of these type of lawsuits cost in taxes and insurance dollars. A "YES" vote on Proposition 103 will put a lid on some of the more frivolous lawsuits, protecting your right not to have your hard earned dollars go to a few greedy lawyers.

Mario Herrera
Tolleson

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

"Our small town has many volunteer community services that are threatened by ridiculous lawsuits. This constitutional amendment will protect our town's most valuable asset – *its volunteers* – by ending the threat of frivolous lawsuits."

Roy W. Hunt, Town Manager
Town of Snowflake

Charles A. Dutcher, Vice-Mayor
Town of Snowflake

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

Law Enforcement Officers are becoming increasingly more apprehensiv about performing their required duties due to the vast numbers of lawsuits being filed against them. This proposition is therefore supported by the Arizona State F.O.P. who feel that it will only enhance law enforcement in the state by allowing duty performance of officers without fear of harassment from and by law breakers. This proposition should maintain the following criteria: In the event a person is injured or property is damaged as a result of actions being taken by a certified law enforcement officer and that law enforcement officer is performing their duty within the guidelines of established state and federal laws as well as their departmental rules and regulations, then that law enforcement officer is protected from lawsuits by that person or owner of said property. Restitution should be the responsibility of the law breaker.

The F.O.P. also feels the only way these vital efforts can truly take effect is with the proposed changes in the State's Constitution as related to the civil justice reform on Article II section 31; Article XVIII section 5 and Article XVIII section 6 of the Arizona Constitution.

Warren L. Hock, Chairman
AZ Fraternal Order of Police
Legislative Committee
Tucson

Margaret Lusk
AZ Fraternal Order of Police
Legislative Committee
Tucson

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

The Arizona Cotton Growers Association urges its members to support Proposition 103. And we further urge the people of Arizona to v te Yes on Proposition 103 to create a fairer legal system and to do away with friv lous law suits.

Rick C. Lavis, Executive Vice President
AZ Cotton Growers Assn
Mesa

Arden J. Palmer, Director f Field Services
AZ Cotton Growers Assn
Mesa

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

The funds utilized to defend an individual or organization against a friv lous lawsuit are often taken from precious monies that should be used to provide additional services to the people in need. This is particularly true in the case f not-for-profits. This fear of these lawsuits have driven many good people out f the helping industries into ther "safer" professions.

Support f this proposition will allow the state to protect professionals and volunteers from frivolous lawsuits and allow these individuals in the helping professions to perform the duties that we, the public, need.

I urge you to support this action and these hard working people.

Hal Elliott, Vice President
St. Paul's Academy
F rmer President of the AZ Council of Children and Adolescents
Phoenix

Maria Hoffman, Executive Director
AZ Council of Children and Adolescents
Phoenix

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

I, and many others, support this initiative as a proposition to amend the Constitution of Arizona. This proposition is important to the people of Mohave County and Arizona because it is the beginning of putting common sense back into the legal system. It will help to end frivolous lawsuits. It will allow legislation that reduces the exposure to liability for emergency medical technicians, firefighters and police officers, charities, schools, landowners, and numerous volunteers.

It will make the felon accountable for their actions. It will put meaning back into the phrase "if you do the crime, you will have to do the time." A beginning to free neighborhoods again, establishes justice and removes profit from the unscrupulous.

Sam Standerfer, Supervisor, District 1
Mohave County Board of Supervisors
Kingman

Pat Chastain, Clerk of the Board
Mohave County Board of Supervisors
Kingman

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

This amendment is the only way to put an end to the senseless waste of the Arizona legal system. As taxpayers and as consumers we are all paying for the high cost of frivolous and unnecessary lawsuits and so the Board of Directors of the Gilbert Chamber of Commerce supports this modification of the Arizona State Constitution as the way to bring about lasting lawsuit reform.

John Gibson, Executive Director
Gilbert Chamber of Commerce
Gilbert

Ron Minske, Board Member
Gilbert Chamber of Commerce
Gilbert

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

Should a business that is trying to stay aflost and provide jobs to people in this time of economic uncertainty have to deal with the fear that it could be wiped out with just one frivolous lawsuit?

Should a man be able to sue a woman jogger for damages he incurred in a car wreck that he caused, claiming that her "attractiveness" made him take his eyes ff the road?

Should a convicted prisoner be able to sue the people of Arizona for damages, or should a gang member be able to sue a family who is trying to make ends meet, when he injures himself while trying to steal their car? These are just a few examples of the frivolous and ridiculous lawsuits that are filed in Arizona each year.

During the 1993 Legislative session, Senate Bill 1055 was passed. This was a positive step in granting immunity to people and organizations against frivolous lawsuits. Unfortunately, the Arizona Trial Lawyers Association managed to get this overturned.

During the 1994 Legislative session, it was brought up under Senate Bill 1305 and was passed by our legislators. Therefore, the most important step in the process is now to reform a very unfair legal system. The way to get that done is to modify the three sections of the Arizona Constitution that relate to the civil justice system.

The Kingman Area Chamber of Commerce strongly supports this change in out legal system and asks that all chambers of commerce and voters in Arizona do as well.

Robert R. Rodriguez, President
Kingman Area Chamber of Commerce
Kingman

Beverly J. Liles, Executive Vice President
Kingman Area Chamber f Commerce
Kingman

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

"The Town of Pinetop-Lakeside is very much in favor of amending these three sections of the Arizona State Constitution and strongly encourage all Arizonans to vote yes on this proposition. Our community is tired of having its services limited because our taxpayer dollars are wasted by paying for foolish and unnecessary lawsuits."

Larry Vicario, Mayor
Town of Pinetop-Lakeside

Paul M. Watson, Town Manager
Town of Pinetop-Lakeside

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

We urge a vote of "YES" for Proposition 103, so Arizona State Association of 4-Wheelers can enjoy the use of Arizona public and private lands for safe four wheel drive recreational use.

Sandee McCullen, Secretary
AZ State Assn of 4 Wheel Drive Clubs
Tempe

Gary Keller, Land Use Chairman
AZ State Assn of 4 Wheel Drive Clubs
Tempe

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "FOR" PROPOSITION 103

Silly lawsuits and unreasonable damage awards cost Arizona consumers and businesses too much money. Often these costs are hidden from the consumer because they are built into the price we pay for goods and services. We can cut these useless costs – Vote YES on proposition 103!

Tom Jones, Executive Vice President
Grand Canyon State Electric Cooperative Assn, Inc.
Phoenix

Sherry Summers, Manager
Grand Canyon State Electric Cooperative Assn, Inc.
Phoenix

People for a Fair Legal System: Joanne MacDonnell, Treasurer

ARGUMENT "AGAINST" PROPOSITION 103

This initiative completely turns around the laws that protect us. The verbs change "shall never" to "may".

This is an insurance company bill.

VOTE NO 103.

Gary Gray, Treasurer
AZ for Pay At Pump (AZPAP), A Far Better Alternative
Glendale

ARGUMENT "AGAINST" PROPOSITION 103

There's a principle older than written civilization which, put simply, says: "You break it, you pay for it." Every civilization has said it, because it's right; but only one, ours, has guaranteed it. And the cornerstone of that guarantee - the only thing that assures it against powerful and wealthy influences - is the right to a trial by jury whenever we're injured by someone else's carelessness or spite.

The framers of both the American and Arizona Constitutions thought these rights and principles were important enough to mention several times in each document. We teach our children these principles because they are morally right and are the "cornerstone of our democracy".

This Proposition is a sweeping change which would effectively take away our right to a jury trial and replace it with politicians' decisions and lobbying influences. It would give the Legislature broad power not only to limit but to actually eliminate our right to be paid for injuries caused by others.

Let me remind you of something you already kn w: once we give up a right, we never get it back, especially if we vote it away. These rights are too important to be given up. They are too fundamental to be "tinkered with." They have been right too long to be changed. They are too personal to be entrusted to politicians.

Vote "NO" on Proposition 103.

Frank X. Gordon, Jr., Former Chief Justice
AZ Supreme Court
Phoenix

ARGUMENT "AGAINST" PROPOSITION 103

The Arizona Constitution represents the best of our 200+ year experiment with freedom and democracy. Drafted in 1910-11, our Constitution was the last, and possibly the best attempt to limit the abuses of special interests in the contiguous 48 states.

It is no accident that Article II (Statement of Rights) includes a specific prohibition against the Legislature ever attempting to limit the power of citizens acting as jurors. The framers of Arizona's Constitution trusted juries of average citizens and knew, from experience, how easily the Legislature could be used by powerful special interests.

It is no accident that Article 18, Section 6, reaffirms the framer's trust in juries and goes on to state citizens' absolute right to seek justice from their peers: "the right of action . . . shall never be abrogated" (abolished). No special interest could ever buy or control a jury of ordinary citizens, while few Legislatures around the country have ever resisted completely the power and money represented by those same special interests.

Proposition 103 is a blatant attempt by national insurance companies to abolish these constitutional protections and put decisions affecting y ur rights into the Legislature where they can more likely control votes. They are even using your premium dollars to finance this campaign to take away your rights!

The Arizona Constitution stands to protect the rights of everyone. It should never be amended to allow special interests like insurance companies to prevail over average citizens it was written to protect. I urge you to vote "NO" on Proposition 103.

David K. Udall
Mesa

ARGUMENT "AGAINST" PROPOSITION 103

Every year, over 24,000 people are killed, and hundreds f thousands seriously injured, by drunk drivers. This does not take into account victims who are injured or killed by all other forms of negligent behavior.

Last year, Mothers Against Drunk Drivers spoke out against the insurance industry's hold on our Legislature as Senate Bill 1055 (now Proposition 301) was pushed through. It is astounding to us that a bill which opens personal medical records to "any interested party", which excuses government from liability for unsafe roads and bridges, and tampers with the jury system for deciding fault and responsibility, could pass so easily.

Contrast that to MADD's four-year, unsuccessful fight to lower the legal alcoh l limit to .08. The legislature seems to have it backwards.

MADD joined many Arizonans in creating and passing the Crime Victim's Bill of Rights four years ago. However, the rights f the victim of negligence hav been established since statehood. The rule of accountability for one's behavior is basic to our form of self-government.

Too often, responsible individuals must rely on our civil justice system to hold people accountable who are negligent and escape any consequences under criminal law. It's tough enough to get a courtroom conviction against the negligent, even drunk, driver. We should not make it any tougher to do so in civil courts.

It is our fundamental responsibility to oppose Proposition 103. Wrongdoers should not be allowed to evade their responsibility while the insurance industry profits at the victim's expense.

We oppose Proposition 103 and urge a NO vote.

Jan Blaser-Upchurch, President
MADD - Pima County
Tucson

Thomas Lee Johnson, Vice President
MADD - Pima County
Tucson

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

ARGUMENT "AGAINST" PROPOSITION 103

Proposition 103 is not a popularity contest about who you like better, one side or the other. It is, by our experience, a practical matter of deciding what's best for you.

The insurance companies supporting this proposition are interested in one thing - money, and the more the better, especially at our expense.

Giving up invaluable and fundamental protections to allow wrongdoers to escape responsibility and big insurance companies to profit is not in our best interest.

As Senior Citizens, we live and lead by example. Our experiences are practical lessons of history. These include survival through the most harsh of economic times; sacrifice through world conflict for the sake of peace; and "good old-fashion horse sense" to deal with shams.

We have the opportunity to teach a basic lesson about right and wrong by saying NO to Proposition 103. Individual responsibility and accountability are principles many have lived by and died for. These principles have always been in our best interest.

Harry C. Cooke
Tempe

Louise Dickson
Phoenix

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

ARGUMENT "AGAINST" PROPOSITION 103

In 1990, the voters in Arizona rejected an insurance company sponsored amendment to the Constitution by the greatest margin ever recorded in the state: 85% against to 15% for. That amendment would have permitted the Legislature to create a "no fault" auto insurance system and, ironically, would have amended the same sections of our Constitution as does Proposition 103.

What part of "NO" don't they understand?

There is no secret to the real agenda behind this proposition. The insurance companies have lined up the votes they need at the Legislature to pass a "no fault" system. That part is easy for them.

The Arizona Republic, in a July 7th story, reported that "If voters accept the constitutional amendment, insurance companies are expected to push for a no-fault auto-insurance system." Many incumbent legislators have said the same in their campaign literature. It's simply no secret that the insurance companies can get from the Legislature what they can't get from you, the voters.

The campaign they are waging in 1994 is clearly more sophisticated and m re clever than what they did in 1990. But the result will be the same. What they call "lawsuit reform" is nothing but a euphemism for "no fault."

"No fault" means good drivers subsidize bad ones. "No fault" means your rates go up after a claim *even if* you did nothing wrong. "No fault" means caps on your medical payments and no protection if your company goes against you.

The insurance companies are nothing if not patient and persistent. T ll them you see through this sham. Tell them AGAIN that you're not interested.

Vote "NO" on Proposition 103.

Randy Gray, 1990 Chairman
Citizens Against No-Fault
Mesa

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

ARGUMENT "AGAINST" PROPOSITION 103

We oppose Proposition 103 because it hurts Arizona families. Most f us are hard-working, play-by-the-rules folks who have just enough to get by. W pay our bills on time, set a little aside for the future and buy insurance to protect urselves against catastrophe.

It's never easy paying insurance bills, what with the cost always going up and the real hope being that you'll never use it. But we do it for our families, kn wing that to not have insurance when you need it is a certain ticket to the welfare rolls. Our children have to be protected.

Most of us don't know much about the law, but we expect it to protect us, too. So when insurance companies pour millions of dollars into political campaigns to change the law, we get suspicious.

Proposition 103 isn't about people getting rights or protection. It's about losing rights and protection. It's about letting insurance companies and the legislators they control make the rules. Right now, the people have a fighting chance. If Propositi n 103 passes, we don't hav a chance.

The real irony here is that the insurance companies are using our premium dollars to pay for this campaign against us. It's not illegal . . . but it's wrong.

We've got to send them a message. Vote "NO" on Proposition 103.

Kay Cline
Earl Cline
Phoenix

Shannon Alexander
Cynthia Alexander
Phoenix

Valerie Smith
Doug Smith
Phoenix

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

ARGUMENT "AGAINST" PROPOSITION 103

Over the past few years, emergency medical care has advanced in keeping injured persons alive. Today, the injured person with a severe head injury has a much-improved chance of recovering and living a productive life. But recovery is an expensive process, one that is as dependent on holding the wrongdoer financially accountable as it is the medical care and technology available. Treatment and therapy have improved, but the cost of these vital services often exceeds $100,000 in the first year of rehabilitation alone. In reality, for the head injury patient, the road to recovery is a slow, tedious, frustrating and *expensive* path to regain personal independence.

Limiting a victim's recovery and excluding negligent people from accountability is wrong and puts an unnecessary burden on us all. The resources of a head injury patient and the patient's family are spent quickly, creating a dependence on available State and County services, systems that are already over-burdened and driving taxes higher.

It is the role of the private-sector insurance industry, with its massive resources, to step to the forefront on behalf of the injured. Yet here, in pushing for the passage of Proposition 103, they do no such thing. Instead, they use precious premium dollars to diminish their own responsibility and increase their financial windfall at the cost of the victims' dignity.

Proposition 103 is the insurance companies' protection act. Its passage would lead to further injury to those who most need help. We oppose Proposition 103 and urge a vote "NO".

Annette Zaccari, President
AZ Head Injury Foundation
Phoenix

David Anderson, Vice President
AZ Head Injury Foundation
Phoenix

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

ARGUMENT "AGAINST" PROPOSITION 103

The Arizona Constitution is currently based on the simple premise that people injured by the negligence of others should be compensated, and that persons who cause these injuries should be held responsible for their actions.

This principle lies at the very core of our social fabric – ur sense of right and wrong – from the 10 year-old who hits a baseball through a neighbor's window to a toxic dumper polluting city wells.

Our civil justice system tries to mirror this basic rule. No, it's not perfect, but it does try to produce fairness and personal responsibility.

It's one thing, however, to recognize the imperfections in a system and another thing altogether to debase it with lies and distortions. Proponents claim that our court system is clogged with "frivolous" suits. Yet the truth, as reported in the June 11th, Arizona Republic, is just the opposite – that fewer cases are being filed. When pressed to give specifics, proponents toss out all manner f unsubstantiated anecdotes – funny stuff, to be sure – but untrue, and straight from the annals of urban legend, like crocodiles in the sewers.

Dan Quayle used to like to say that America has 70% of the world's lawyers and spends $100 billion a year in wasteful litigation. It struck a cord and the insurance companies loved it. Unfortunately, it ain't so. America has only about 3% of the world's lawyers, which isn't bad considering Bosnia has alm st n ne. And the total cost of personal injury litigation runs about $4 billion, roughly half of what we spend on cigarettes and a bit more than we buy in hot dogs.

Vote "NO" on Proposition 103.

Randy Gray, Chairman
Fairness and Accountability in Insurance Reform (FAIR)
Mesa

ARGUMENT "AGAINST" PROPOSITION 103

The following Analysis was prepared by legislative staff. They felt it was an accurate and impartial analysis of the effect of Prop 103, which is what state law requires them to prepare. The staff worked on this for weeks before submitting it to legislators on the Legislative Council Committee for inclusion in this very pamphlet.

But it was never even considered.

Instead, Senate President John Greene, co-chairman of the insurance company-funded campaign for Prop 103, wrote the other argument entitled "Analysis by Legislative Council" that appears a few pages before this. The President then convinced other legislators to insert his argument in place of the impartial analysis by staff.

We urge you to read both. You be the judge of the Legislature's impartiality.

"ANALYSIS BY LEGISLATIVE COUNCIL

(In compliance with A.R.S. section 19-124)

The Constitution of Arizona provides that no law eliminating the right to sue for death or injury and no law limiting the amount of money to be recovered can be enacted. The Constitution of Arizona also provides that in a lawsuit the jury determines all questions relating to the legal defense of 'contributory negligence' or 'assumption of risk'.

This proposition would amend the Constitution by:

1. Allowing the Legislature to enact laws that would eliminate a person's right to bring an action to recover money r benefits f r injuries,

2. Allowing th Legislature to enact laws that would limit th amount f money or benefits a person could recover for death or personal injuries, and

3. Allowing the Legislature to enact laws that would remove the defense of 'contributory negligence' or 'assumption of risk' from the consideration of a jury."

Vote NO on Prop 103.

Jim Roush
Tempe

Fairness and Accountability in Insurance Reform, (FAIR): Randy Gray, Chairman

BALLOT FORMAT

PROPOSITION 103

PROPOSED AMENDMENT TO THE CONSTITUTION BY THE INITIATIVE

OFFICIAL TITLE

PROPOSING AN AMENDMENT TO THE CONSTITUTION OF ARIZONA; AMENDING ARTICLE II, SECTION 31, CONSTITUTION OF ARIZONA; AMENDING ARTICLE XVIII, SECTION 5, CONSTITUTION OF ARIZONA; AMENDING ARTICLE XVIII, SECTION 6, CONSTITUTION OF ARIZONA, RELATING TO CIVIL JUSTICE REFORM.

DESCRIPTIVE TITLE

AMENDING THE ARIZONA CONSTITUTION TO ELIMINATE THE PROVISIONS PROHIBITING THE LEGISLATURE FROM RESTRICTING THE RECOVERY OF DAMAGES FOR PERSONAL INJURIES, THE CONSIDERATION OF CERTAIN DEFENSES BY A JURY, AND THE AMOUNT OF DAMAGES RECOVERABLE FOR DEATH OR INJURY.

PROPOSITION 103

A "yes" vote shall have the effect of amending the Constitution to eliminate the provisions prohibiting the Legislature from restricting the recovery of damages for personal injuries, the consideration of certain defenses by a jury, and the amount of damages recoverable for death or injury.

YES ➡

A "no" vote shall have the effect of keeping the current constitutional provisions regarding the recovery of damages, the consideration of certain defenses by a jury, and the amount of damages recoverable.

NO ➡

Rural Physician Study Committee
Proposed Recommendations Options

Version #1:

The Rural Physician Study Committee encourages the Legislature:

(a) to continue to monitor the medical malpractice insurance problem in this state, given the important and evolving nature of this issue; and

(b) to work collaboratively with stakeholders and develop strategies that meet the goals of affording victims of medical negligence fair compensation, and ensuring available and affordable liability insurance to all medical practitioners.

Version #2:
(a & b – Dr. Carland)
(c – Sen. Arzberger)
(d – Rep. Hanson)

The Rural Physician Study Committee encourages the Legislature:

(a) to continue to monitor the multiple and complex issues affecting the delivery of medical care in this state, given the important and evolving nature of this issue; and

(b) to work collaboratively with stakeholders to develop strategies that meet the goals of ensuring the availability of qualified healthcare personnel at all levels of the health care system, enhancing quality medical care and reducing medical errors, adequately compensating those injured by negligent medical care while ensuring balance in assessing medical negligence, and promoting the availability of (and viability of the companies providing) liability insurance to qualified medical practitioners.

(c) Encourage members of this committee, other interested legislators, hospital administrators and medical professionals to continue the discussion at the legislature as an informal working group, and seek options to address the problems of high malpractice insurance costs and the retention of physicians, particularly in rural areas.

(d) Request that a standing committee of the House and/or Senate such as Insurance/Finance investigate the possibility of placing limits on malpractice suits; thus encouraging physicians to continue to maintain their practices in rural communities.

Rural Physician Study Committee
ADOPTED Recommendations

The Rural Physician Study Committee encourages the Legislature:

(a) to continue the study committee with a new charge to monitor the multiple and complex issues affecting the delivery of medical care in this state that focuses on professional malpractice liability on access to care and quality of care and on critical issues relating to physicians, hospitals and nursing homes.

(b) to work collaboratively with stakeholders to develop strategies that meet the goals of ensuring the availability of qualified healthcare personnel at all levels of the health care system, enhancing quality medical care, adequately compensating those injured by negligent medical care while ensuring balance in assessing medical negligence, and promoting the availability of (and viability of the companies providing) liability insurance to qualified medical practitioners.

(c) to request that a standing committee of the House of Representatives and/or Senate such as Insurance/Finance investigate the possibility of placing limits on malpractice suits; thus encouraging physicians to continue to maintain their practices in rural communities.